Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, ptI, perPHYS, G893,7/7/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Alda M. Amorim 8:22 P M June 22 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 🛛 F 577-58-0593 79 October 7, 1929 Portugal Usual Residence of Decedent 10a. State 10b County 10c. City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5702 Anniston Road 20817 Portugal 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nanny Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Maria Victoria da Silva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annabella A. Bethke/Daughter 5700 Anniston Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 26, Montgomery Crematorium Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Barnhart M01546 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Shock Days disease or condition resulting in death) Due to (or as a consequence of): Cardiorespiratory Arrest Minutes Sequentially list conditions if any being L immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 💢 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-tran and Division of Vital Records, P.O. Box 68760. physician the the signed by 1 I be detach has director, page certificate funeral After death. after death Director: A I in by the f

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ed other than "natural", or items 23a or 28a-f show event, the Medical Examinational Le notified at

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Mangnes.

Physician

/Medical

Examiner

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death

filed within 72 hours after

3altimore, Maryland 21215-0036

Hospital or Attending within 2 To the

State Registrar

determined

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

June 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Thai McGreivy, 9901 Medical Center Drive, Rockville, Maryland 20850 M.D.

31. Date filed (Month, Day, Year) JUN 26 2009

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05/^{Day}2009^{Year} 7:20 a M Husein Alijanovic 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/22/1949 5. Social Security Number 7. Age (In vrs. last birthday) Min Bosnia 578-29-9358 60 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 20902 USA 12211 Edgemont St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Electrical Engineer 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alija Mujagic Ibahim Alijanovic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bethesda, MD 20814 4922 Battery Ln. Apt#4, Sandra Damadzic / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Cem. 07/07/09 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Li Universal Mortuary Inc. 411 Kennedy St. NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1-2 month Metastatic Small Cell Cancer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Date of delivery entribute to the cause of death? 3€ Probably 4 Unknown b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other (Specify)

Physician /Medical Examiner burial-transi Division of Vital Records, P.O. Box 68760,

720 AIN

Alcjanovic, Husein 7/5/9

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

"natural", or

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trains

with

72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

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MD

traumatic event, the Medical Examerinust be notified at

Examine led by the attending physician and detached for use as the burial-tran Physician/Medical cate has been signed by page 2 should be detact ģ Completed filled in by the funeral director, Be Certification: To Hospital or Attendi 24 hours after death. Funeral Director: A To the Hospital within 24 hours a To the Funeral L

that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
Liver failure,	Renal failure	1 ☐ Yes 2 ☐ No 3💢 Probably 4 ☐ Unkr
		24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings avaited the prior to completion of causideath? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ∐ Yes 2 反 No	Hospital: 1 Tinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 150 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

29a. Certifier

Eric

(Check only

29b. Signature and title of certifier

D.

MD

29d. Date signed (Month, Day, Year) 07/06/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

8600 Old Georgetown Rd. Bethesda, MD 20814

D0060117

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

31. Date filed (Month, Day, Park,

Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:20 A M 2009 26, Daniel Anderson June Jason /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Dunda1k 8011 Mid Haven Road 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Nov. 16, 1974 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Numb Funeral 217-04-0**550**6 Days Hours Months 1**X** M 2□ F 34 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nutified at Dunda1k 1 ☐ Yes 2 No Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 8011 Mid Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Sheet Metal Worker 10 Years r arked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is rierked oth any injury or other traunictic event Be Helen Williams Arthur Anderson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Spencer West Virginia 209 Clover Road Mr. Arthur S. Anderson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 6/30/2009 Bel Air, Maryland Bel Air Mem. Gdns. 4 Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. any in Dundalk, Maryland 21222 7922 Wise Ave. 23a. Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final v 2 months **Physician** unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and transit death certificate be executed Due to (or as a consequence of): burialphysician s the burial O. Box 68760 Physician/Medical as attending p IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached fo ☐Yes 2☐No 9 Unknown 9 Unknown 4 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records. à 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has 2 No certificate 1 ☐ Yes the Hospital or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the Funeral Director: After this of the Funeral Director. After this of the funeral director the funeral director the funeral director the funeral director that the funeral d ၉ this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury (Month, Day, Year) 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Bremera June 2009 D002883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 Browner 4940 ALLO Baltionore, Eastern tronue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#7,8, perFH, G893,7/10/09, WS

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Dav **Physician** 2009 4:15P Dorothy Zeun Benbow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Cockeysville Broadmead 8. Date of Birth 915 (Month, Day, Year) Sept 7, 1989 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. Months Days 1□ M XX F Sept Yrs. 215-01-2256 93 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic evant, the Medical Examiner rust be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21030 13801 York Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or Items 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White 3XXWidowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If item 27 is marked other than Secretary Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Russell Greer Louise Browning Linhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy L Dennis Dtr 1018 East 10th Street Berwick Pennsylvania 18603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any njury or Loudon Park Cemetery | July 9,2009 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of FacMitchell-Wiedefeld Funeral Home In Signature of Funeral Amice Ligensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or comporations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 🗌 Yes 2 D No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Voursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 3□ DOA 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deal To the Funeral Director; 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) RD., COCKEYSVILL 32. Reg State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Elizabeth M. Beyer 10:45 AM 30 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3102 Cardinal Way Abingdon Harford If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🖫 F Days Hours 218-42-0928 85 Director 13 1924 England Jan Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Model Examiner must be notified at MD Harford Abingdon 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3102 Cardinal Way 21009 England Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. White þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 Sam Fowler Mable Hutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If Item 27 is any Injury or other trau Mark Hoffman /son 3210 Meadow Valley Drive Abingdon MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OAk Lawn Cemetery 7/2/09 4 □ Donation 5 □ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 MAce Ave. Balto. 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 mth /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed and burial-Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending p for use a IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Frobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Batto

State Registrar

Day, Year) JUL 07

31. Date filed (Mo)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year PM M. Budres Dorothy 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosedalt Baltmon Sayare 8. Date of Birth Jan 8, 1933 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Days Hours 215-30-3055 1 □ M 2 🕮 F MD 76 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Essex 1 ☐ Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 1000 Franklin Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Title Co. Elementary/Secondary (0-12) College (1-4or 5+) Processor 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MArie Struck Charles Budres 19b. Mailing Address (Street and Number or Rural Royte Number, City of Town, State, Zip Code) 305 Locust Lane Belair MD 21014 19a. Informant's Name/Relationship (Type. Print) Dianne Letke /neice 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 7/3/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD 21. Signature | Fu eral Service Licenses 21221 Oli Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SHOCK Day entic Du to (or as a consequence of): ntumenia Sequentially list conditions, if any, leading to in mediaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Certification: To

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Registrar

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, It agnee.

Baltimore, Maryland 21215-0036

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burial-tran attending physician the for use ned by the a detached for icate has been si , page 2 should b certificate

P.O. Box 68760,

Division of Vital Records,

funeral director, this

law requires that the death certificate be executed Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

1∐Yes 2⊠No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and

5 Pending investigation

6 ☐ Could not be

title of certifier

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and ess of

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ers in who completed cause of death (Item 23a) (Type, Print)
TAZA (IZVI) MO. 9000 FVAI 9000 Franklin Square Drive Baltimore MD 21237 MO. SYED MURTAZA

31. Date filed (Month Day, Year) 0 7

Mano 8-420 Box 68760. Division of Vital Records,

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State Registrar

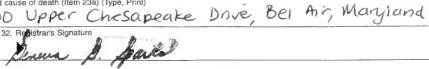
DHMH 17 Rev 1/2001

Fistler, 500 31. Date filed (Month, Day, Year)

MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Christa



29c. License number

July, 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HENRY W. BIEMAN **Physician** 8:00 A M 01 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Millersville Anne Arundel 247 Severn Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 23, 1924 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 217-12-3589 85 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important; if item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, it means are accounted as a second or a second Millersville 1 ☐ Yes 2 No Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21108 USA 247 Severn Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 A Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Construction Company Carpenter 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adolf Bieman Marie Kluck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 247 Severn Road, Millersville, Maryland 21108 Frances L. Bieman (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Memorial Park 7/3/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WC1111y-Folymak Funeral Rome, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 3204 Mountain Rd., Pasadena, Maryland, 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fi I Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C TECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_ 1	For State Registrar Certificate of Death	Reg. No. 0 0 0 1 5 0 0
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) ARGARET ABANOS 2. Date of D Month O6	27 2009 0334 M
Examine Funeral Director	er	222-26-7170 1 66 Yrs. April	Anne Arunde1 irith Day, Year) 9. Birthplace (State or Foreign Country) 11,1943 Ohio
Maryland I-f show fied at		Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 ☐Yes 2 ☑No
ath with the s 23a or 28a	Dire	10e. Street and Number 6840 Montgomery Road 21075	10g. Citizen of What Country? U.S.A. 14. Race - American Indian,
72 hours after death with the Maryland natural", or items 23a or 28a-f show dicel Examinat must be redified at	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:	Specify: White
within than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) The secondary (0-12) College (1-4or 5+) N/A School Bus Driver	Montgomery County Sc
should be filed and Mental Hygi s marked other umatic event,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Tonah Calvin Hogan Maryhelle	le, Maiden Surname) Rurris
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type. Print) Catherine Lisa Banos—McDevitt (Daughter) 7965 F. Shore Rd. Pa 20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 □ Removal from State 4□ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Catherine Lisa Banos—McDevitt (Daughter) 7965 F. Shore Rd. Pa 20b. Place of Disposition (Name of cemetery, crematory or other place) Gracelawn Mem. PK. 07/02/09 22. Name and Address of Facility McCully—Polyniak Funeral 3204 Mountain Road Pasad	Sadena, Maryland 21122 20c. Location - City or Town, State New Castle, Delaware
hysician /Medical Examiner	Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to numericale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	arrest, Approximate Interval Between
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this certifical director,	To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No	topsy prior to completion of cause of death? s 22No 1 Yes 2 No y one) prior to completion of cause of death? 1 Yes 2 No y one)
after death. Director: After in by the funer	Certification:	1.	n (Street and Number or Rural Route Number, Town, State)
the nospital hin 24 hours the Funeral upletely filled	edical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to to the death occurred at the time, date and place, and due to the death occurred at the time, date and death occurred	ne, date and place, and due to the cause(s)
Within Comp	M	29b. Signature and title of certifier 29c. License number 21438	29d Date signed (Month, Day, Year) June 29, 2009 H WAY ANNAPUIJMOL
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1/7

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State Registrar 29b. Signature ar

STUGST

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

leted cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

JACOBL

29d. Date signed (Month, Day, Year)

305 Hospital Dr. Glon Burnis, MD 21061

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09-05165 Nathaniel Britt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	al Exami	12/2	Nathaniel Britt		June 30, 2009
		4	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Anne Arundel
			Rt 97 Northbound South of Quarterfield Bouleverad	Glen Bumie	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
	Funeral		6. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Country)
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	er dez		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: BOCK
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2121	uld be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Examin	a	Benjamin Britt	Gerale	Iral Route Number, City or Town, State, Zip Code)
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Ĕ	Pages 1 ment of F tant: If i		4 Donation of Other Opegay:	22. Name and Address of Facility	9/2009 Crownsville, MD
Baltimore.	permit. Page Department o Important:		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Rd Jessup ND 20794
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		Ш	Sequentially list conditions, b.		
		ner	if any, leading to immediate cause. Enter Underlying Couse		
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Bov 687	leath certifica e attending pl for use as th	Physician/	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)	
	it the d	Ph	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
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5	vician Necessity visiting the last certificate la director, page	B B	examiner? Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other Nursin	g Home 5 Residence 6 Other: Scene
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O oproved letty to noticing	or Attence or Attence of Attence of Attence of Director:	Certification:	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ë		i i	4 Homicide determined (Specify) Major Road / H	ngritta)	or Town, State) Rt 97 Northbound South of Quarterfield B, Glen Burnie ,
0	UIVISIOI OI VICAI NECOLUS, F.C. DOX DOX DOX DOX DOX To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in whe funeral director, page 2 should be detached for use as the burial - transi	je	29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and	due to the cause(s) and manner as stated.
	Fo the	Medical	and mailler stated.	29c. License number	29d. Date signed (Month, Day, Year)
		Ž	29b. Signature and title of certifier	O.C.M.E.	July 1, 2009
			MI / MI		, , , , , , , , , , , , , , , , , , ,
ì			30. Name and address of person who completed cause of death (Item 23a	r 111 Penn Street, Baltimore, M	D 21201
	1		Russell Alexander MD. Assistant Medical Examine	TITI GIIII SUGGI, DAILIIIIOIG, W	
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	barle	OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 645AM Boyer Jean 4009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North West Hospital Baltimore Ranallstown If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🖾 F 87 046-18-2688 Director March 6,1922 PA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Examinar count be natified at Director 1 ☐Yes 2 No Mn Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 716 Pamela Road 21061 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No White <u>۾</u> Specify: 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If M. M. ODGe. College (1-4or 5+) Shipping Office Bethleham Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank August Lentes Helen Kimmel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1655 Colony Road Pasadena MD 21122 Mr. David Boyer/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July Date 9 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 2009 Glen Burnie, MD Atlantic Crematory 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Mo1220 Services PA 1 2ND Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, 🕶 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE ITEMET FAILURE END STAGE /Medical Due to (or as a consequence of): Examiner CORONNY Gequentles, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MITERY Due to (or as a consequence of): Examine by Physician/Medical Р Completed 2 Be Medical Certification: To

To the Hospital or AttendIng Physiclan: The law requires that the death certificate be executed گ Division of Vital Records, P.O. Box 68760, چ physician and the burial-trans attending p for use as t signed by the a page 2 s filled in by the funeral After after death within 24 hours a

To the Funeral C

completely filled

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

or items 23a or 28a-f show,

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resulting in death) Last	Due to (or as a conseq	uence of):		10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -	
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Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	751	se contribute to the cause of death? No 3 Probably 4 Unknown
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25. Was case referred to medical		-	26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 【XNo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 ☐ Residence 6	Other (Specify) HOSPICE
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fact (y)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
	ysician: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated. I place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

0, State

Registrar

31. Date filed (Month, Day, Year)

Deberah

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith Avonce Sufe 200 Baltmore MD

Box 68760, Ö ۵. Records, Division of Vital or Attending the Hospital

within 24 hours a To the Funeral D completely State

the

filled in by

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

6 Could not be determined

14201 Laurel Park Drive, #103 Casas, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Registrar

1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

D24997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20707

July 6, 2009

Laurel, Maryland

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:40 A M EDWINA WHITE BEYER 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Jun 17, 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔀 F Connecticut 1932 Director 046-24-0436 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City. Town or Location 10b. County show if than "natural", or items 23a or 28a-f show 1 ☐Yes 2▼ No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 205 St. Mark Way #526 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s any injury or other traumatic event, it of Marical Examination by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣No Specify. White 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Lucien White Catherine Ann Heaphy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Catherine DeFilippo/daughter 11727 Devilwood Drive Potomac, MD 20854 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 07/06/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Mones Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🗷 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospite Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Spec \(\text{Spec} \) \(\text{VOUF} \) \(\text{Nouff} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signati MD 434235 ess of person who completed cause of death (Item 23a) (Type, Print) DV MONIT NARANG ENTERST WESTMINSTER, MD+151 31. Date filed (Month, Day, Registrar's Sign State 072009 Registrar

	Physicia /Medica Examine	
ı	Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar		Ce	rtificate	of Death			Reg. No.	_000	21010
Physicia		Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medic		Kathleen Ann Bow						July	_	009	8:15 P M
Examin	er	4a. Facility Name (If not institution, give stre	et and number)			n, or Location	of Death			County of Death	
Europal		Dove House 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If Under 1 Y	inster ear If Under		8. Date of Birt (Month, Da		rroll 9. Birth	place (State or Foreign
Funeral Director		220-50-4632	2 7 F	51 Yrs.	Months D	ays Hours	Min.	May 24			ginia
MO TO		10a. State 10b. County	10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
a-f sh	ctor	MD Carroll	Fir	nksbur	a						1 □ Yes 2 💆 No
or 28	Director	10e. Street and Number			10f. Zip Co	de				zen of What Cou	intry?
s 23a		2428 Appaloosa Way		- 132	21048				USA		land ladies
items	Funeral	11. Wantai Glatos	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	.S. 13.	Was Deceden If Yes, specify	of Hispanic Oi Cuban, Mexica	rigin? (Spe in, Puerto	ecity Yes or No Rican, etc.))-	 Race - Amer Black, White, 	
ral", or Exami	þ	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 X	No Specify	r:			Specify: Whi	ite
"natu	Completed	15. Decedent's Educat (Specify only highest grade co	ompleted)	(Give	edent's Usual C e kind of work o DO NOT use r	one during mos	st of worki	ng	16b. Kii	nd of Business/II	ndustry
r than	omy	Elementary/Secondary (0-12)	College (1-4or 5+)		stered	,			Hea	lthcare	
other other	BeC	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle,	, Maiden	Surname)	
Menta irked itic e	P E	Lawrence Wesley Do	ane			Mary	Pati	ricia C	inqu	ina	
aith and 27 is me r traums		19a. Informant's Name/Relationship (Type. Thomas W. Bowen, J	1		ing Address (S Calver					Town, State, Zi 21 8	ip Code)
Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State Fir	Place of Disponentery, cre	osition (Name ematory or othe urney C	of r place) remator		oate /06/09		cation - City or T bine, M	
Departri Importa any inju once.		21. Signature of Funeral Service Licensee	104		_					P.O. Box	
		23a. Part 1, Enter the disease, or complicat	ions that caused the dea	1.251_iBe	everly	L. Heck	rotte s cardiac	P.A. or respiratory a	Cla	rksville	Approximate
		shock, or heart failure. List only one	cause on each line.								Interval Between Onset and Death
ysician /ledical		disease or condition resulting in death)	Metastatic (Due to (or as a consec		or Bre	ast					
aminer		Sequentially list conditions b.	Congestive H		Failure						
÷;	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec			_					
al-tran	Examiner	that initiated events c resulting in death) Last	Chronic Obst Due to (or as a consec		ve Pulm	onary D	ıseas	se		-	
ysicia ie buri											
ng ph as th	Medical	IF FEMALE:									
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	sician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	☐ Ectopic preg				1	23d. Date of deli Month	very Day Year
gned b	by Phys	Part II. Other significent conditions contri		_	underlying caus	e given in Part	I.				the cause of death?
een si		Diabetes Mellitus,	Hypertension	on				1 💢	Yes 2[∏ No 3 ☐ Pro	obably 4 ☐ Unknown
ate has b	Completed							24a. Was auto perfo 1 □ Yes		prior to death?	topsy findings available completion of cause of 2 □ No
ctor, p	Bec	25. Was case referred to medical examiner?				1	e of Deat	h (Check only			
this or	P P	1 ☐ Yes 212 No	pital: 1 ☐ Inpatient 2 ☐								cify) hospice
ath. r: After e funera	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time Injury		Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe	how injur	y occurred	
s after des	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, s	treet, factory, of	fice		28f. Location (City or To			ral Route Number,
e Funera	Medical (29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	ian: To the best of my kn r: On the basis of examin and manner stated.	owledge, dea ation and/or	ath occurred at investigation, in	the time, date a my opinion, de	and place, eath occur	and due to the red at the time	e cause(s , date and) and manner as I place, and due	stated. to the cause(s)
To th	Me	29b. Signature and title of certifier	DAAQUE	M		icense number 218				te signed (Month	
5 v		30. Name and address of person who com				nd nach	M	21157			
Sta	te.	Raman Kaneria, M.D 31. Date filed (Month, Day, Year)				unster	, MD	2115/			
Registr		JUL 07 2009 A	32. Registrar's sign	gar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jackson Burns 9:05PM Helen 27 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7017 Graces Quarters Road Baltimore Co. Middle River If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🛛 F 87 237-20-7372 South Carolina March 14,1922 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Wedical Examination at 1 ☐ Yes 2 X No Middle River Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 7017 Graces Quarters Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify. þ 3 ₩ Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) Government Administrative Assistant 12 Years Year 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Sallie A. McCloud Willie A. Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7017 Graces Quarters Road Middle River, MD 21220 David W. Burns Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/2/2009 Cumberland, MD Sunset Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4000 **Physician** M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be execute sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tes icate has been si ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐Yes 2 ☐NO 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated within 2 To the I the

State Registrar 31. Date filed (Month Day, Year)

JUHL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

Aue, Batto, M.D. 2/22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Bundra R. Andrew 9:40 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Nursing Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1⊠ M 2□ F Yrs Nov. 13,1932 Pennsvlvania Director 76 545-46-4349 Usual Residence of Decedent illed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experies must be notified at 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 21222 United States 8161 Gray Haven Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1√gYes 2 No IfYes, Give Year or Dates: Korean 1 Never Married 27 Married 0 Maryland 21215-0036 1 ☐ Yes 2X No Specify. \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 12 Years 2 Years Salesperson Gourmet World 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Stephanie G. Matejewski Andrew J. Bundra ဂ (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8161 Gray Haven Road Dundalk, Maryland 21222 Health a Mrs. Virginia Mae Bundra Department of Health Important: If item 27 any injury or other trong once. 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State St. Andrew Orthadox Cem. 7/3/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signaty e //Funeral Service Licen 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final BOWER OBSTRUCTION **Physician** MALIGNANT DAYS disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner 2004 COUN CANCET if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine sician and burial-trans Due to (or as a consequence of) physician a Physician/Medical law requires that the death certificate attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ned by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ISCHEMIC CARDIOMYOPATHY page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBRILLATION has autopsy perform certificate 1 ☐Yes 2 ☐ No CORONARY ARTERY 1 ☐ Yes 2 No DISEASE Sadyad, HUSAEN. Division of Vital 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) • Hospital or Attending Pl 24 hours after death. • Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D64395 JUNE 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOBERMAN, MP BACTMORE, MO 21204 DANIEUE 555 WEST TOWSONTOWN BLUD

State Registrar

DHMH 17 Rev 1/2001

ricgistrai

31. Date filed (Month, Day, Year)

LO 12009 Jenus S. gara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 11 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Month **Physician** Sherman Bluc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JCCOVIS Baltmore Baltmore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 1. 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, 9. Birthplace (State or Foreign Country) UNK Funeral Days Hours 216-42-9492 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show must be notified at MD Baltimore Baltimore City 1X Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 21218 items 23a 1102 Druid Hill Avenue 12. Was Decedent Ever in U.S. Armed Forces?Unk 1 □ Yes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unic injury or other traumatic event, the Medical Evaruitate 1 ☐ Never Married 2 ☐ Married Specify: black Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 🖾 No Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gass & Electric unk Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Sherman T. Blue, Sr. Lillie Gibson ပ 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
151 Wilgate Rd. Baltimore, MD 21117
2000 W. Baltimore Street Baltimore, Maryland 21223 19a Informant's Name/Relationship *(Type. Print)* Lillian Perry Bon Secours Hospital Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/21/09 MD National Park Baltimore, MD 22 Name and Address of Facility Wesley Chavis, Jr F.H. Store Anatomy Board 555 W. Baltimore. Baltimore, Maryland 21201 21231 ature of Funeral Service 3a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Uncease of highly that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions conditions to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 HNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Ves 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. To the Hospital or Attendivithin 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Physician: The law requires that the death certificate be executed P.0. Records, Division of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Maryland 21215-0036

Baltimore,

Certification: To

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my profile and the cause of the caus Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 0065485

06/28/2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barbara Supanich, M.D., 1500 Forest Glen Drive, Silver Spring, MD 20910

State Registrar

reparech 18m MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elizabeth Barrett 11:55 AM Margaret JUNE 30th 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ST. AGNES HOSPITAL BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Norths | Days | Hours | Min. | Oct | Month 1 Days | Year 917 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 91 220-09-6053 1 ☐ M 2 🔀 F Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Evan Inc. out be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 435 Westshire Dr. 21228 USA of Health and Mental Hygiene.

'Item 27 is marked other than "natural". or lucation other traumant. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be G. 2 Bowersock Ethelyn L. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenore A. Liberto (Daughter) 409 Maryland Ave., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 7/3/09 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Easter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a NON ST-ELEVATION MYOCARDIAL INFARCTION **Physician** unknoon /Medical Due to (or as a consequence of): Examiner GASTROINTESTINAL BLEEDING unlanoon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit HYPERTENSION unknown Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery NIA 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) P.O. NIA 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Hospital or Attending Physician: The performe 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the vithin 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 17.0. globle D0066262 JUNE 30th, 2009 900 CATON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGDALENA STARBAN ST, AGNES HOSPITAL, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 07 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of	Marylan	d / Depa	rtment of F	lealth and l	Mental Hy	giene	0.0	01521
_			State Registrar			Cer	tificate of	Death		Reg. No.	09	21321
	Physici	an	1. Decedent's Name (First, Middle,						2. Date of De Month	-	Year	3. Time of Death
li i	/Medi		Lois Ann		hrens				July		2009	8:26 PM
	Examir	ner	4a. Facility Name (If not institution,			.	4b. City, Town, o	r Location of Death			nty of Death	1
			Harford Memo 5. Social Security Number 6	rial Ho	spita] 7. Age <i>(In yrs.</i>	last hirthday)	Havre If Under 1 Year	de Gra		Harf		nplace (State or Foreign
	Funeral Director		441 54 7469	1□ M 21XF	61	Yrs.	Months Days	Hours Min.	(Month, Da	1948 1948	Cou	intry) many
			Usual Residence of Decedent						1,20	1040		
J	ıryları show	_	10a. State 10b. County	3		y, Town or Loc erdee!						10d. Inside City Limits Yes 2 □ No
000	the Marylan r 28a-f show	ecto	Maryland Harfor	ra —————	AD	erdeei						
9	with the	٦	10e. Street and Number		_		10f. Zip Code			10g. Citizen o		intry?
2036 pm	eath with	eral	306 Stevens C	ircle #	2A dent Ever in II	S 13 V	21001		pecify Yes or No	U.S.7	ace - Amer	ican Indian
0 -	fter deat	ᇤ	1 Never Married 2 Married	12. Was Deced Armed For 1 Tes	ces? 2 X No	I		lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	В	lack, White	
10 9 215-0036	n 72 hours afte "natural", or i	Completed by Funeral Directo	3 □XVidowed 4 □ Divorced	If Yes, Giv	e	1	□Yes 2 🖾 o	Specify:		Spe	^{cify:} Whi	.te
5-0-5	nin 72 ho e. un "natur Medical	etec	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup	oation during most of wor d)	kina	16b. Kind of	Business/li	ndustry
	within ene. than "	d d	Elementary/Secondary (0-12)	College (1-	4or 5+)	_	_	d)	9	_ + h		
W 22	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter than "natural", or items 23a or 28a-f show out, the Medical Examinational by natified at	ပိ	12 17. Father's Name (First, Middle, La	et)		nome	maker	18. Mother's Nan	ne (First Middle	at h		
and	d be f ental ced o	o Be	George Mitche	•				Leana	,			
7/J	should mark marti	은	19a. Informant's Name/Relationship	-		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numb	er. City or Tov	vn, State, Z	ip Code)
	alth a 27 is		Raymond Fulle	r (son)		306	Stevens	Circle	#2A,	Aberd	een,	MD 21001
re.	iftern rothe		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of actory or other place	ce)	Date	20c. Locatio		
altimore.	Page Tent ant: II		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Mem. Gd		y 9,09	Aber	deen	, Maryland
Salt	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other than y injury or other traumatic event, I'm once.		21. Signature of Fundral Service Lu	ensee		T ²²	Name and Addre	argo Fu	neral	Home,	P.A	1 0 0 1
34 B	20 5 6 9		Did Ire	nly		33	3 S. Pa	rke St,	Abero	leen,	MD 2	
1.7			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	mplications that ca ily one cause on ea	used the deatl ach line.	h. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	5/	Ble	ed.					
0	/Medical Examiner		1	Due to (d	or as a consequence	uence of):	- 1					
u		ē	Sequentially list conditions,	b. One to (c	ir BB 0 numawo	uinea of):	ante					
1 6.	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
7,0	e exerian ar	EX	resulting in death) Last	Due to (d	or as a consequ	uence of):						
# 8760	cate be executed physician and the burial-transit	dical		d								
9		Mec	IF FEMALE:	ODe lives outs								
4 MH O. Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta ant at time of c	death 3	Ectopic pregnand Other <i>(specify)</i> _	у			Date of deli Month	very Day Year
	the di	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unkno		ieaiii 5	Tottler (specify) _					
9.	2 0 9		Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
\V \ \frac{5}{8}	quires en sig uld be	q p	,						1 🗆	Yes 2□No	3 ☐ Pr	obably 4 Donknown
OIS Records.	aw aw	Completed by							24a. Was		b. Were au	topsy findings available
	The law ate has b	E O							auto perfe 1 □ Yes	ormed?	death?	completion of cause of 2 \Box
S, Z	Physician: this certific	Be	25. Was case referred to medical examiner?					26. Place of Dea				
V) =	hysk this c		1 ☐ Yes 2 ☐ No		npatient 2			4 Li Nursing F	lome 5 ☐ Res			cify)
EH REW Division of	Jing F After funera	io i	27. Manner of Death 1 Natural 5 Pending	1 '	of Injury h, <i>Day, Year)</i>	28b. Time of Injury	28c. Injui Wor M 1	ryat k? Yes 2 ∐ No	28d. Describe	how injury occ	curred	
Risi	Attending r death. ector: After by the fune	ficat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 290 Place	of Injury - At ho	me farm stre	et, factory, office	lies Z [INO	28f. Location	Street and Nu	mber or Bu	ıral Route Number,
EH REND Division o	after after Dire	Certification: To	4 ☐ Homicide determine	ed buildin	g, etc. (Specif	y)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Bi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page			Physician: To the taminer: On the ba								
3	To the hwithin 24	Me-fical	one) 29b. Signature and title of certifier	and mann			29c. Licens			29d. Date of		
~	F≥F8		A Z	21 1	C 5A	112E+	451	188	88	7/4	1/09	9145 AL
	•		30. Name and address of person wh	no completed cause	e of death (Item	1 23a) (Type I	Print)	000				
			HOUTAN SAR		,			E DE GA	PACE A	10 21	07%	,
	Sta	te	31. Date filed (Month, Day, Year)	32 Re	egistrar's Signa				12	0-1	<i>U</i>	
	Registr	ar	.1111 0 7 20	109 /2	was !	9. dea	Mad					

		•	For State Registrer	State of Maryla		artment of H rtificate of L		ntal Hygiei Reg.	21119	21522
	Physici		1. Decedent's Name (First, Middle, Last Linda L. Connors	•			2.	Date of Death Month July 1,	Day Year	3. Time of Death 8:42 A M
1	/Medic Examin		4a. Facility Name (If not institution, give Stella Maris 5. Social Security Number 6. Security Number 11	ex 7. Age (In y	rs. last birthday) O Yrs.	4b. City, Town, or Timon If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth	4c. County of Death Baltimore	
	Director show	or	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo		0	ct. 22,	1940 Ma	10d. Inside City Limits 1 □Yes 2√□No
	ath with the A 23a or 28a-	ral Director	Maryland Baltimor 10e. Street and Number 616 Milford Mill	Road	Pikevil	10f. Zip Code 21208			Citizen of What Cou	
9800	within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Middeal Exer, but , ust be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 ⊠ No	ispanic Origin? (Specif n, Mexican, Puerto Ric Specify:		Specify:	white
Baltimore, Maryland 21215-0036	within jiene.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired er's Assi	furing most of working ()	16b	Education	,
/land	2 should be filed vand Mental Hygie Is marked other is aumatic event, trans	To Be ($ \begin{array}{ccc} \hbox{17. Father's Name (\it First, Middle, Last)} \\ \hline \textbf{Thomas} & \textbf{Kelly} \end{array} $				18. Mother's Name (F Edna Ka		den Surname)	
, Mar	es 1 and 2 should of Health and Mer item 27 Is marke r other traumatic		19a. Informant's Name/Relationship (7. Edward Connors	Husband	616 M	ilford Mi	and Number or Rural F	ikesvill	le, MD 21:	208
timore	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Du	laney V	natory`or other plac alley	7/6/20	09 Tin	c. Location - City or T nonium, Ma	aryland
Bal	perm Depa Impo any ii		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compshock, or heart failure. List only of	den	116	30 Edmond	ss of Facility Ster1 ne of Caton lson Avenue	; Catons	sville, M	D ZIZZO Approximate
	Physician /Medical Examiner	iner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		FEMULTI sequence of):		JKOENCEPHAL			inferval Between Onset and Death
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
O. Box	death certi e attending d for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of prediction 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3[☐ Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
ords, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	nderlying cause give	en in Part I.			o the cause of death? robably 4 🙀 Unknown
Vital Records,	The la ate has	Completed	25. Was case referred to medical				OO Direct Dook (24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Division of Vit	ding Phys n. After this funeral dir	Certification: To Be	examiner?		r) 28b. Time o	f 28c. Injur Worl M 1 🗆	y at 280 Yes 2 No	5 ☐ Residence	injury occurred	HOSPICE
Divi	Hospital or At 24 hours after of Funeral Direct rtely filled in by		4 Homicide determined	28e. Place of Injury - A building, etc. (Spi ysician: To the best of my	ecify)			City or Town, S		
P	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner: On the basis of exam and manner stated.			opinion, death occurred	at the time, date		e to the cause(s)
			30. Name and address of person who	completed cause of death (ltem 23a) (Type,	Print)	3725		7/110	19
	Sta Registr		TARIO MAHMOOD, N 31. Date filed (Month, Day, Year)	32. Begistrar's Si	gnature		TIMONIUM, M	D 21093		
DH	Registi MH 17 Bev 1/2		JUL 0 7 200	19 Semma	B. A.	ake	<u>,</u>			

8:42 a.m.

JULY 1, 2009

LINDA CONNORS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 900 A M **Physician** Walter J. Connell Sr. 2 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rosedale Baltimore FRANKLIN SQUARE HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June | 18,1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F MD 220-20-4866 83 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Rosedale 1 ☐ Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 7409 Gold Field Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White <u>۾</u> 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gas&Electric Co. Foreman 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth M. Kanuff Joseph J. Connell ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5152 Brightleaf Court Balto. MD 21237 Bill McHenry /Step-son 20b. Place of Disposition (Name of cemetery, crematory or other place).
Gardens of Faith 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 7/6/09 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part I. Enter the discase, or charge cations that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List hijly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1+spircha (or w a consequence of): Sequentially list conditions, it any, leading to in medic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a our sequence of) Examine 0 Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

physician and the burial-transit Box 68760. attending p for use as t P.0. icate has been signed by the page 2 should be detached Hospital or Attending Physician: The law requires that Records, certificate Division of Vital After th funeral death. the Funeral Director: after To the Hospital within 24 hours a To the Funeral C

Funeral

Director

show

28a-f

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or items 23a

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

OR Sebastian 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certified

Clown S. Gards

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K

Year)

John

M, 0

9000

32. Registrar's Signature

29c. License number

00055171

FRANKLIN SQUARE DR

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 1:20 P M Nellie Anna Cupp July 05. 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 ▼ F 78 03/06/1931 Marvland Director 213-28-8508 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hygelen. In Pepartment of Health and Mental Hygelen Important: it flem 75 is marked other than "natural" or items 23a or 28a-f show any injunt: if item 75 is marked other than "hadical Exyminal must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Dunvale Road Apt. 408 21204 US.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: ğ Specify: White 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Foster Medical College (1-4or 5+) Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Catherine Benda Christopher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bradley/ Sister 4604 Ballygar Rd. Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Parial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/09/09 Rosedale, MD Cemetery
22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Baltimore, MD 21234 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immigrate Cause (Final disease or condition resulting in death) CANCER -UNG **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to forces a gonsermence of Examiner burial-transi and Due to (or as a consequence of): Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 🔲 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1XYes 2 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn After this certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) OSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Check only 29b. Signature and title of pertifie

Registrar

DHMH 17 Rev 1/2001

State

THUNIUM

of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANCY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year July **Physician** 2, 10:10 PM Lester Gilbert Coen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**½** M 2 □ F Yrs. Director 81 7, 1928 <u> 215-32-7836</u> <u>Maryland</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Montal Hygiene. larked other than "natural" or items 23a or 28a-f show netic event, tra Marical Examiner must be notified at 10b. County 1 ☐ Yes 2 ▼No Director Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 Park Beach Drive 21001 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2**∑**No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ammunition Handler U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilton Rekord Coen Edith Lenora Gallion ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau Gregory W. Kuester / Nephew 307 N. Hickory Ave., Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland Baker's Cemetery 7-7-09 21. Signature of Funeral Service License 22. Name and Address of Facility
MCCOmas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GTASTATIC CANCER, **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Be (25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105f1CE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely

The law requires that the death certificate be executed Records. Vital or Attending Physician: ō Division 24 hours after deatl Funeral Director: Hospital

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with the Maryland

death v

Is marked other

and

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

within 2 State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and the of certifier

f person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD THONIUM, MD

JONES (31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 30, 2009 3:02P M Cowen Irven Robert June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 537 Hawthorne Road Linthicum Anne Arundel 8. Date of Birth (Month, Day, Year) Oct. 12,1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X**] M 2□ F 80 MD 214-22-8482 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedisal Examinat must be notified at MD Anne Arundel 1 ☐ Yes 2 No Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 537 Hawthorne Road 21090 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 DYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White <u>م</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Supervisor Gas & Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irven Franklin Cowen Mary Elizabeth O'Neill ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jeffery Cowen/ Son 3300 Jarrettsville Pike Monkton MD 21111 other t item Date V 7, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ju1y ̃ Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vets. Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 NO1357 an Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 18MD Metasterti /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🔼 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 2 □ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To the Funeral Director: After the completely filled in by the funeral

Medical

31. Date filed (Month, Day, Year) Registrar

29a. Certifier

29b. Signature and title of certifier

(Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D35

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carole Millen Mp

900 Catronave

32. Registrar's Signature 0.7.2009

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	Department of Health and Me Certificate of Death		2000 21527
			Registrer 1. Decedent's Name (First, Middle, Last)		Reg. No.	3. Time of Death
	Physicia		Agnes Louise Carnes (AKA Sr. Mary	Mark Carnes, I.H.M)	Month Day June 26	6:00 A M
And By	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	LXaiiiii	CI	2907 Dunleer Road	Dundalk	В	Baltimore Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		169-42-2794 81	Yrs.	(Month, Day, Year) Nov. 5,192	27 Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	Maryl f sho	ō	Maryland Baltimore	Dundalk		1 □Yes 24(X)No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. Citi	zen of What Country?
	h with	al D	2907 Dunleer Road	21222	Uni	ted States
	ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show final Examinat must be incitified at	γFι	1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
Ş	hour tural	ed t		Decedent's Usual Occupation	16b. Kii	nd of Business/Industry
215	nin 72 In "na	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)		
21215-0036	d with	Completed by Funeral Director	12 Years 6 Years	School Principal	E	Education
nd	be filed tall Hygid doubler	Be (17. Father's Name (First, Middle, Last)		First, Middle, Maiden	
<u>Y</u>	ould i	٦	Patrick Joseph Carnes	Frances	-	
Maryland	d 2 sh th and 7 Is n traun			Mailing Address (Street and Number or Rural Solution Spring Road		, Maryland 21222
e,	1 and Heal tem 2		Transco ratio	f Disposition (Name of party, crematory or other place)		ocation - City or Town, State
100	Pages ent of nt: If i			ry, crematory or other place) ed Ht. of Jesus Cem. 6,	/30/09 Du	ndalk, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it at leafied Examination and amy injury or other traumatic event, it at leafied Examination.		21. Signature of Funeral Service Licensee	20 Name and Address of Facility		
Ä	permi Depa Impo any Ir once.		1000 CO	Duda-Ruck Funeral 1	ndalk, Mar	yland 21222
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	OTIL COLONARY ARTE	RY DISENS	SE 1988
	/Medical Examiner		resulting in death) Due to (or as a consequence			
		e.	Sequentially list conditions, and the sequence by the sequence of the sequence	600		
(uted	Examiner	Gause (Disease or injury that initiated events			
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		0	IF FEMALE:			
Вох	death certific e attending p ed for use as	ian/	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Q	0 0 0	Physician/M	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Li Other (specify)		
٠ <u>.</u>	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
rds	quires an sign uld be	ed by	BREAST CANCER IN REMISE	01	1 □ Yes 2	No 3 Probably 4 ☐ Unknown
Records,	e law requir has been s e 2 should i	plet	POLYMYALGIA PHEUMOCA		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Œ.	The	Completed	CONGESTIVE HEART FAIL		autopsy performed?	death?
/ita	ician: Th certificate ector, pag	Be (25. Was case referred to medical	26. Place of Death		
of Vital	Physician: this certific ral director,		1 Yes 2 Hospital: 1 Inpatient 2 □ ER/Ou	·	e 5 Residence	
N C	Jing F	ion:	Natural 5 ☐ Pending (Month, Day, Year)	Time of 28c. Injury at 28f. Work? M 1 □ Yes 2 □ No	3d. Describe how injur	y occurred
Division	Attending Physician: r death. ector: After this certifice by the funeral director, p	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, fa	100	Bf. Location (Street ar.	nd Number or Rural Route Number,
	al or / s after I Dire d in b	Certification: To	4 Homicide determined building, etc. (Specify)		City or Town, State	1)
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier (Check only Medical Examiner: On the basis of examination at	e, death occurred at the time, date and place, a	nd due to the cause(s	and manner as stated.
2	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) and manner stated.	29c. License number		tte signed (Month, Day, Year)
	5 5 wit	_	29b. Signature and title of certifie	29c. License number 00029197	290. Da	LIDG
7			20 Normal address of server with a server death of the Co.		10/2	-0/07
-			30. Name and address of person wild completed cause of death (Item 23a) J. MICHAR MEHOR M 9101	FRANKLIN SQUARE OR	-205 DA	21237
	Sta	te	31. Date filed (Month, Day, Year) Registrar's Signature	7 1 1 1 1 2 2 1 1 1 1	13/	
	Registr	ar		Rike		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Year **Physician** 7:10 PM Potta 06 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayview Care Conte ohns Hopkins Ba hmo manucin 6. Sex 1X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 217-09-0775 Director 2,1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b County 10a. State 10c. City, Town or Location ral", or Items 23a or 28a-f show Evanimer must be notified at ¥Wes 2□No Director N/A Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 5505 Bayview Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married more, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3₺ Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Service Station Attendent Fuel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental H item 27 Is marked oth Be and Mental Grace Rinaldi Salvatore Culotta ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7112 Olivia Road Middle River, Maryland 21220 Vincent P. Culotta, Jr. (Son) Department of Healt Important; If item 21 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns, 6/29/2009 4 ☐ Donation _5 ☐ Other (Specify) Middle River, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the shock, or heart in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. ease Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) /Medical **Examiner** scular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physiclan: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of 68760 Physician/Medical Box IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No certificate Vital 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 27. Mannet of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) **Division** 1 Natural 5 Pending investigation 2 Accident 1 □Yes 2 🗌 No death. Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar

31. Date filed (Month, Day,

07

. Registrar's Sig

5 Hopkins Bay view circle faltoning

09-05262 Oscar B. Camp Мe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

р		1- For State Registrar	. Of Maryland	Certifica			ia ivicin	ar riyg		g. No. 2	0.0	9 2152
Physicia dical Exami	n/	1. Decedent's Name (First, Middle,L							Date of Death Month	Day Yea		3. Time of Death 1355 hrs
alcai Exami		Oscar B. Camp 4a. Facility Name (if not institution,			4	b. City, Town, c	r Location o		July 4, 200	4c. County	of Death	
		Baltimore Washington N				Glen Burni				Anne Ar		10.
Funeral Director		094-14-3269	Sex 7. Age	e (In yrs. last birth	Yrs.	If Under 1 Ye Months Da		Min.	8/23/1	L920		place (State or Foreign htry) Y York
any	ł	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Locatio	on						10d. Inside City Limits
land f show	ē	FL Palm Be	each	Boca Ra	ton							1 Yes 2 X No
h the Mary 3a or 28a-	I Director	10e. Street and Number 7560 Fairmont (Court			10f. Zip Code 33496	5		10	g. Citizen of W	hat Coun	ry?
ifter death wit II", or items 2 ner must be r	y Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	1 X Yes 2	Ever in U.S. No WII	If Ye	S Decedent of Hes, specify Cuba	an, Mexican,				e - Americ e, etc. Wh i	an Indian, Black,
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12)		5+) de	uring mo	's Usual Occup ost of working lif Cian				16b. Kind of Bi		dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	8	17. Father's Name (First, Middle, La Romolo Campone		L			18.Mother'		irst, Middle, N Bambace	Maiden Surname	∌)	
ore, MD 2121 st and 2 should be for Health and Mental If item 27 is marked	ဥ		o(Type, Print) mp / Wife	7	560	Fairmor	nt Cou	irt l	Boca Ra	ton, Fl	_ 334	196
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Menial Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Spec		cremato	ry or oth	tion (Name of control		7/7/2	Date 2009	20c. Location	•	ryland
Balt permit. Depart Import injury		21. Signature of Euneral Service Lice	2.50		Ruc		on Fun	eral				204 'ork Road
Physician /Medical kaminer		23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease			enter th	e mode of dying	g, such as ca	ardiac or re	espiratory arre	est, shock, or he	eart	Approximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a conse	equence of):								
2	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse		-0							
760, cicate be executed physician and the burial - transit	_	events resulting in death) Last	d	squence ory.								
760, icate be e physicial the burial	Medica	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome	ne of pregnancy						23d. Date o	f delivery	
Box 687 he death certific	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		time of death 5		tal death 3 ner (Specify)	Ectopic	pregnanc	;y	Month	D	ay Year
P.O. I	by Ph	Part II. Other significant condition	ns contributing to death	h but not resulting	in the u	nderlying cause	given in Pa	art I.				he cause of death?
cords, law require has been si 2 should b	Completed t								24a. Was autop	an 24b.	Were aut	opsy findings available ompletion of cause of
of Vital Rec ling Physician: The After this certificate I		25. Was case referred to medical				26.Pia	ce of Death	(Check on	1 Yes	2No	1 🗸 Ye	s 2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No		ent 2 🗸 ER/Ou			Other;			Residence 6	Other	
ion of Itending P leath. Tor: After		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investig		ry 28b. T rear) 1300	ime of Ir hrs		jury at Work Yes 2	. Is		now injury occur down stairs	rred	
Division Bopital or Attendig 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Could r 4 Homicide	not be 28e. Place of In	jury - At home, far ngle Family	m, stree	et, factory, office	building, et		or Town, S			ral Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exami	sician: To the best of m ner:On the basis of examination and manner stated.			ion, in my opinie	on, death oc			and place, and	due to the	e cause(s)
	Σ	29b. Signature and title of certifier	allan				nse number C.M.E.			29d. Date sign		nth, Day,Year)
20%		30. Name and address of person who Carol Allan, MD Assis	no completed cause of distant Medical Exar		Penn S	Street, Baltir	more, MD	21201			::::::::::::::::::::::::::::::::::::::	
St Regist	ate rar	31. Date filed (Month, Day, Year)	2000 32. Registra	r's Signature	1							
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			1 _ State	ate of Maryland / I		rtment of H		, 0	ene g. No. 2009	21530
			Registrar 1. Decedent's Name (First, Middle, Last)		00,	imodic or i		2. Date of Death	g. No. 2_ 0 0 2	3. Time of Death
	Physicia		Carolyn Mae Dukehar	t				July 3	, 2009 Year	6:00 A M
The same	/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Death		4c. County of Dea	th
		2011	42 James Street				ninster		Carrol1	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last bit	rthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 28	9. Bir Co , 1912 Mai	thplace (State or Foreign ountry) cvland
			Usual Residence of Decedent						,	
	arylar show	_	10a. State 10b. County	10c. City, Tow	n or Loc	ation				10d. Inside City Limits 11☑Yes 2□No
	he Ma 28a-f	Directo	Maryland Carroll	West	nins					
	with t		10e. Street and Number			10f. Zip Code	-		g. Citizen of What Co	ountry?
	ns 23	Funeral	42 James Street	as Decedent Ever in U.S.	13. W	2115			USA 14. Race - Ame	erican Indian.
39	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Evarinet must be notified at	b	1 Never Married 2 Married 1	med Forces? ∐Yes 2 X2 No Yes, Give ear or Dates:		Yes, specify Cuba □Yes 2 [™] No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
ŏ	2 hou	ted	15. Decedent's Education		. Deced	ent's Usual Occupa	ation	1	6b. Kind of Business	/Industry
Maryland 21215-0036	within 7 ene. than "r	Completed	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4or 5+)		ind of work done o O NOT use retired aker	luring most of work)	ing	Own Home	
1d 2	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M	,	
ylaı	nould by d Ments narked natic e	To	John E. Evans					e Gallag		
<u>a</u>	and 2 st lealth and m 27 is n her traun		19a. Informant's Name/Relationship (Type. Pa Rose Mary Kane Daug						City or Town, State, Maryland	• /
e,	s 1 ar of Hea item		20a. Method of Disposition	20b. Place o		ition (Name of atory or other place			Oc. Location - City or	
<u>=</u>	Page nent c int: If iry or		1 XBurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State New C	athe	dral Cem	etery 7/		Baltimore,	the second secon
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Language	410#	Fu.	Name and Addres	ss of Facility Steme of Cat	rling As onsville	hton Schwa	ab Witzke
	402 40		232 Part 1. Enter the disease, or complication	MOI537	-16	30 Edmon	dson Aven	ue; Cato	nsville,	
			shock, or heart failure. List only one cau Immediate Cause (Final	ise on each line.	١.			or respiratory arres	51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		12812	w th	11 20128			2 Hours
	Examiner			Due to (or as a consequence	•	90				30 48ARS
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	บนะ เป (o as a consequence						1
۵.	ecute ind transi	Examiner	Cause (Disease or injury that initiated events							
760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	of):					
687	ificate g phys is the	edical	d	**						
Box	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me	in the past 12 months?	yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death		Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
Р. О	at the	hys	9 🗆 Unknown	Unknown						
rds,	w requires that the de been signed by the should be detached		Part II. Other significant conditions contribut	ing to death but not resulting i	n the un	derlying cause give	en in Part I.			o the cause of death? robably 4 Unknown
Records,	has e 2	Completed by						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
_	ilcian: The la certificate ha ector, page?		05. W					1 ☐ Yes 2	☑No 1 ☐ Ye:	s 2 No
	Physician: r this certific ral director, I) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospit	al: 1 ☐ Inpatient 2 ☐ ER/O	utnotions	3□ DOA Othe	251	h (Check only one,		
	ding Physician: h. After this certifics funeral director, p	n: To	27. Manner of Death 28	a. Date of Injury 28b.	Time of	28c. Injury Work	4 LJ Nursing no	28d. Describe how	nce 6 Other (Special of the Control	эсігу)
Ö	5 2 2 3	atio	1	(Month, Day, Year)	Injury		Yes 2 □ No	*		
DIVISION	al or Attends after death	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
0	To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by th	ledical ((Check only 2 Medical Examiner: 0	To the best of my knowledg On the basis of examination and and manner stated.	e, death nd/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	· m	\	29c. License	number	29	d. Date signed (Mon.	th, Day, Year)
			30. Name and address of person who complet	-			(1)		2.0	7,204
,	Sta	to	John Lalin (Month, Day, Year)	32. Registrar's Signature	3 0	eren du	ive ;	To wise w	MO.	01047
	Registr		JUL 0 7 2009	Genera B.	bar	Las I				

2. Date of Death

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Funeral Director

the Maryland show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinan man Louis Lines and death v permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or from any injury or other transment.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and burial-tran the attending physician Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760

12:32 PM Ronald Burton Dowell 03, 2009 July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Min. Months Days Hours 1 X M 2 □ F 217-56-8254 82 1927 Scotland April 11. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Harford MD Fallston 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 1337 Vouloir Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting 12 CPA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Dowell Eleanor Cooland ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 932 21st Street South, Arlington, VA 22202 Michael Dowell/ 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel – Bel Air 20c. Location - City or Town, State Date 20a. Method of Disposition 07/05/09 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 23 . P.11. Enter per disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or he ry failure. List only one cause on each line. 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death NON-SMALL CELL FEBRUARY 2008 Due to (or as a low equence of): Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ⊒Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) #OSFICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21204 DOBERMAN, MO 555 WEST TOWSONTOWN BLVD

State Registra

DANIEVE

31. Date filed (Month,

JUL ()

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To the Within 2

park

32. Restrar's Signature

Denolfi, Elizabeth Baltimore, Marvland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Plea	ase Type or P			delible Ink. artment of F		-	_		
	1 - State Registrar Certificate of Death							Reg. No. 2009 21532			
Physici	an	1. Decedent's Name (First, Middle, Last)					· · · · · · · · · · · · · · · · · · ·	2. Date of De Month	2. Date of Death Month Day Year 3. Time of Death		
/Medic	al	Elizabeth M. DeNolfi							02 2009 4c. County of Dea	12:30PM	
Examin	er	4a. Facility Name (If not institution, give street and number) Berlin Nursing And Rehabili			itayion 4b. City, Town, or Location of Death			Worcester			
Funeral		5. Social Security Number	. Age (In yrs.	e (In yrs. last birthday) If Under 1 Year If Under 24 Hrs				rthplace (State or Foreign ountry)			
Director		218-01-1149 1 M 2 Yrs. Months Days Hours Min. May 6, 1911 Maryland Maryland									
yland how		10a. State 10b. County			10c. City, Town or Location					10d. Inside City Limits	
th the Marylar or 28a-f show	ctor	Maryland Worcester			Berlin					XXYes 2 □ No	
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. Ital cother than "natural", or items 23a or 28a-f show event, if the filed Error, interior and interior a	Funeral Director	10e. Street and Number 9715 Healthway Drive			10f. Zip Code 21811				10g. Citizen of What C	g. Citizen of What Country? USA	
ms 23	neral	11. Marital Status 12. Was Decedent I			S. 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		pecify Yes or No			
or ite		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ★ If Yes, Give		™ No		r Yes, specify Cuban, Mexican, Puerto i I □Yes 🏖 No Specify:		o Rican, etc.)	1	te, etc. hite	
hours tural",	ed by	3 ⚠ Widowed 4 ☐ Divorced Year or Dates:			16a. Decedent's Usual Occupation				16b. Kind of Business/Industry		
in 72 in "nal	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-		or 5.	(Give	kind of work done during most of working NOT use retired)		ng	Tob. Nina di Basiliess/Industry		
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be file	Be	17. Father's Name (First, Middle, Last) John Vicchio			18. Mother's Name			e (First, Middle, Maiden Surname)			
should nd Me mark mark	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip								Zip Code)	
y We		John J. DeNolfi			14 C	arnegie E	Place, Oc	ean Pin	es, Marylan	d 21811	
Pages 1 lent of H nt: If iten ry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation / 5 ☐ Other (S		9	emetery, crei	osition (Name of matory or other place W Memoria	al 7/7/	Date 2009	20c. Location - City of Sykesville,		
pormit. Pages 1 and 2 should be filed within D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It. In once.		21. Signature of Funeral Service	-	. 11) B	2. Name and Addre urgee-Her 631 Falls	ss of Facility. SS-Seitz	Funera	l Home, Inc	. 21211	
	20-1	23a. Part 1. Entry ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Onset and Death									
Physician										Onset and Death	
/Medical Examiner		resulting in death)	1-11-1								
	ler	Sequentially list conditions, if any, leading to immediate	r as a conseq	a consequence of):							
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the H thin 24 the Fi	Medical	one) and manner stated.									
To with		Mullulus 11/2 bas/5 7/2 ba								tin, Day, Year)	
2 /		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type,	Print)	21111 0	14,183	DA AI	CHUAY AAD	
Sta	te	31. Date filed (Month, Day, Year)	32. Rg	histrar's Signa	ture	CATIC	1(10)/	IVILE	11-11/11	21824	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year Muriel Duchardt Bouton 5:00PM 5 2009 July , 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex (In yrs. last birthday) Days Hours 1 □ M 2X F 90 067-16-5914 Vrs 12/04/1918 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Venice 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sterling Road 3565 34293 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Social Services 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Clougher Hazel White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Bouton - Yant / Daughter 122 Wagner Way, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 7/7/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall X-Q Maishall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TROKE disease or condition resulting in death) Due to (or as a consequence of): EKEBROVASCULAR DISEASE DIAGETES Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Hinknown 9 Unknown

Physician /Medical Examiner

that the death certificate be executed

for use

director, page 2 should

Completed

Be

Certification: To

Medical

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Records,

Vital

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Division

Hospital or Attending

death.

within 24 hours after deatl To the Funeral Director: filled in by the

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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filed within 72 hours after death with the Maryland

1 and 2 should be filed withir Health and Mental Hygiene.

Pages 1 ₹

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Important; If it any injury or o

Jepartment

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

Physician/Medical þ

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC KIONEY DISCASE ENDOMETRIAL CANCER

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSA CE 28d. Describe how injury occurred

29a. Certifier (Check only

3 ☐ Suicide

4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

investigation

6 ☐ Could not be determined

D64395

29d. Date signed (Month, Day, Year) JULY 6,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHAMES ST, SUITE ZOG BALTMORE, MD Z1204 DOBERMAN. MO DANIEUE 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July Dav 2009 Year **Physician** 10:29 P M 3. Shirley Evans /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Davs Hours 1 □ M 2 X F Months 220-40-9742 68 Director Feb. 13, Maryland Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10b County If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Medical Examiner must be notified at 1 ÄYes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1504 Belt Street 21230 U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked and injury or other. 1 Never Married 2 Married 1 ☐ Yes 2 No ģ Specify: 3 XWidowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/Ă Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maynard L. Harris Margaret ٥ Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Showalter (Brother) 1105 Weldon Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cem, :07/08/09 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licensee McCinian Polyniak Tuneral Home, P.A. 130 East Fort Avenue Baltimoré, Maryland 21230 23a. Part 1. 5 filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: esn yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ģ in the past 12 months? Month Day Year 1 □Yes 2 No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 robably 1 ☐ Yes 2 🗌 No 4 🔲 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t page 2 autopsy certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 1 ☐ Yes Certification: To 1 Inpatient After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or impostigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, 29b. Signature and title of certifier

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Pr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 🦳 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dealt **Physician** DOROTHY **FARKAS** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 01/02/1921 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗙 F Months Days Hours Min 070-16-2377 88 NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 No Directo BALTIMORE MD OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT, #355 21117 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No Specify. þ Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ART EDUCATION TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC BRAUNSTEIN IDA KATZ ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4936 BRIGHTLEAF COURT, BALTIMORE, MD KENNETH FARKAS / SON item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 07/06/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner h116 Sequentially list conditions if any leadin, to imm, Jut cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine consequence of The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has bracter, page 2 s OSKODOYOSU autopsy spital or Attending Physician: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, pay 2. No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 Tyes 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

5401

Old

ovit Rd

Randallstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Ida B. Griffin 10:19 A M 07 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Square Kosedale 8. Date of Birth (Month, Day, Year) Feb. 13, 1915 If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 214-24-0605 1 □ M 2 € F 94 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County Show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Mcdi-al Examiner must be 721 Seneca Park Road 21220 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify þ 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 4th permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important; If Item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harrison Hilda Arnold ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Shelton /daughter 726 Senca Park Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Parkwood Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 7/6/09 Parkville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22, Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List prily one cause on each line. immediate Cause (Final Disease **Physician** Ischemic bowel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of): Examiner burial-trar Due to (or as a consequence of) physician Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day 5 Other (specify) ☐ Yes 2 No been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performe 1∐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗷 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician; within 24 hours after death To the Funeral Director: the Hospital

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month,

ii wh

29b. Signature and title of certifier

30. Name and address of pers

(Check only one)

completed cause of death (Item 23a) (Type, Print)

29c. License number

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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Drive Baltimole, md

9000 Year) 32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MINE Deloris R. Gerchman /Medical Jown, or Location of Death 4b. City Facility Name (If not institution, give street and number Examiner BALTIMOREKLASHINGTONN EDICAL LENTER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 8, If Under 1 Year If Under 24 Age (In yrs. last birthday)
79 Yrs. 5. Social Security Number **Funeral** Days 1 □ M 2 🖾 F MD 213-24-3797 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a State ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinat must be notified at 1 ☐ Yes 2 No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 U.S.A. 1140 McHenry Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Army Claims Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Edgar Raymond Mitchell Cora Goldie Willie ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a fitem 27 is Mrs. Sharon M. Wallace/Daughter 1140 McHenry Drive Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Laurel, Maryland Emmanuel Meth.Ch.Cem. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee any Mo/357 Services PA 1 2nd Ave. SW Glen Burnie, MD, 21061 Varien 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, cate has been signi page 2 should be o Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident hours after deat ineral Director; 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9

			For State Registrar	otate of Maryland	Certificate of	Death	Re	eg. No.	1 0 0 0				
	Physicia	an	Decedent's Name (First, Middle, La	MARY GLORIA G	ILES		2. Date of Death Month	Day Year	3. Time of Death 41.28 P M				
	/Medic Examin		4a. Facility Name (If not institution, given Manor Care of Du		4b. City, Town, Towson	or Location of Death		4c. County of Death Baltimore	.1				
Ī	Funeral Director			Sex 7. Age (In yrs. last 1 M 2 1 F 81	yrs. If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, July 14, 1	Year) Cou					
	aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, To	own or Location Baltimore				10d. Inside City Limits 1 ☑ Yes 2 □ No				
	with the M a or 28a-f Le rotiffs	Funeral Director	10e. Street and Number 600 Light St.,	Apt. 715	10f. Zip Code	21230	10	Og. Citizen of What Cou	ntry?				
920	urs after death al', or items 23 Examinar mus	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cui	Hispanic Origin? (Spe can, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W					
Maryland 21215-0036	within 72 ho ane. than "natur e Medicel I	Completed by	15. Decedent's E (Specify only highest green (Secondary (0-12)		6a. Decedent's Usual Occi (Give kind of work done life. DO NOT use retir Homemaker	pation during most of workingd)	ng	16b. Kind of Business/Ir Housewife & M					
land 2	ild be filed lental Hygie kad othar ic avent, II	To Be Co	17. Father's Name (First, Middle, Las John				e (First, Middle, Maiden Sumame) Ridgell						
	and 2 shou lalth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi, Robert M. Carlin (Godson) 102 Perry Rd., Colebrook, New Hampshire 035										
Baltimore,	the death certificate be executed by by the attending physician and ached for use as the burial-transit ached for use ached for		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec	□Removal from State Holy	etery, crematory or other pl Cross Cemetery	7/3/0	9	20c. Location - City or T Baltimore, Mar	ryland				
Balt			22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 130 Fast Fort Ave., Baltimore, Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										
		er	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequent) Due to (or as a consequent)	toid Art	nritis uns	in 7 4	est,	Interval Batween Onset and Death				
68760, -	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Conges Due to (or as a donsequen Chroni	tive Hea c OKn		lune ction	1					
P.O. Box 6	the death certific y the attending p iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnan	cy		23d. Date of delin Month	very Day Year				
	quires that n signed b uid be deta	ğ	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause o	iven in Part I.		bacco use contribute to es 25No 3☐Pro	the cause of death?				
Records,	The law requir ate has been si bage 2 should l	Completed					24a. Was a autops perform	sy prior to c	opsy findings available ompletion of cause of				
ital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?		0.	26. Place of Death	(Check only or	ne)					
on of Vital	ling After fune	ုင	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28	Bb. Time of 28c. In Injury			ence 6 Other (Specow injury occurred	ify)				
Division	To tha Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Ose Blees of lower At home	e, farm, street, factory, offic	9	28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,				
2	ha Hospit n 24 houn he Funara bletely fille	Medical C	29a. Certifying F (Check only one) 15 Certifying F 2 Medical Example 16	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	edge, death occurred at the n and/or investigation, in my	time, date and place, opinion, death occurr	ed at the time, d	late and place, and due	to the cause(s)				
	To the within	×	29b. Signature and title of certifier	relibio.		0 5 4 4 7	1	29d. Date signed (Month					
			30. Name and address of person who	o completed cause of death (Item 23	Ba) (Type, Print)	#LZ B	reakly	yn, MD Z	21225				
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July Day **Physician** 2009 Delores Carita Gil1 6:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. 1□ M 210 F Months Hours 71 212-34-8779 Aug. 17,1937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7466 East Furnance Branch Road 21060 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 K Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Bar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Bowen Erma Yoccobel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Peter Gill /Son 83 Pioneer Ridge Drive Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any infury or concept. to 1 ☐ Burial 2 🎇 Cremation 3 Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD neral Service 22. Name and Address of Facility Singleton Funeral & Cremation Moizzo Services 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner . H**ospital or Attending Physician**: The law requires that the death certificate be execute 24 hours after death. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ bronic Obstructive Pulmonary (1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed oronan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1°☑ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Birnbaum, M.D. 500 Upper Chesapeake Dr. Bel Air, mo 21014

10056296

State of Maryland / Department of Health and Mental Hygiene 4

M

	Physician
	/Medical
	Examiner
_	Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

1 - For State Registrar 1. De

Certificate of Death

ecedent's Name (First, Middle, Last)		ate of Death	5 V	Time of
Helen Ruth Herbert	J.,	lonth	Day Year 7	210
acility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	D 1-11-6		D = 1 + d	

Seasons Hospice 5. Social Security Number

4a. F

Director

Funeral

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Completed

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Examine

Physician/Medical

ğ

Completed

Be

Certification:

cal

6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🖼 F Months Days Hours

Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min.

Sept. 7, 1922 Maryland

214-16-5653 Usual Residence of Decedent 10a. State 10b. County

10c. City. Town or Location

Lochearn

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

USA

Maryland 10e. Street and Number

11. Marital Status

Baltimore

10f. Zip Code 21207 10g. Citizen of What Country?

Specify:

6825 Campfield Road

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

14. Race - American Indian, Black, White, etc.

White

1 □ Never Married 2 □ Married 3 Nidowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

1 ☐ Yes 2 👿 No 16a. Decedent's Usual Occupation

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

(Give kind of work done during most of working life. DO NOT use retired) Clerical Office Staff

Sales & Distribution

17. Father's Name (First, Middle, Last)

Clara Belle Graves

Daniel Willis Seibert

19a. Informant's Name/Relationship (Type. Print) Judith E. Herbert Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2277 Dunster Lane; Potomac, Maryland 20854

20a. Method of Disposition

Date 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery 7/9/2009

20c. Location - City or Town, State Woodlawn, Maryland

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sc

MO1537

22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc.

18. Mother's Name (First, Middle, Maiden Surname)

Part r. Enfer the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final

Q = 5.00 ...

1630 Edmondson Avenue: Catonsville. MD 21228 Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

disease or condition resulting in death)

Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

100		WOY W	CHEVIO
Due to	or as a c	onsequence	of):
End	Sto	06 0	bronie (

Due to (or as a consequence of)

structure Pulmonay Diseas Due to (or as a consequence of)

Physician /Medical Examiner

attending physician and for use as the burial-tran

signed be det

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy

3 Ectopic pregnancy

23d. Date of delivery

Year

9 Unknown

☐Yes 2☐No

1 Live birth 2 Fetal death
4 Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death? 2 🗖 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 No မ 27, Manner of Death

4 ☐ Homicide

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

Hospital: 28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Nother Specify 175816 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed'

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buten 5401 Old Court Koad

31. Date filed (Month, Day, State Registrar

32. Registrar's Signature

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

P.O. Division of Vital Records,

Box 68760.

Physician: The law requires that the death certificate be executed

Hospital or Attending

after death.

io the within 24 hou. The Funeral D'

21541

			1 - State Registrar			Cer	tificate of	Death		Reg. No.			
			1. Decedent's Name (First, Middle, L				2. Date of De	eath 3. Time of Death					
	Physici /Medio		Charles	Dennis Ha	aines,	Sr.			July	3	2009	9:00 P M	
-	Examin		4a. Facility Name (If not institution, g					r Location of Death			ty of Death		
			Golden Living C					tminster			arrol		
	Funeral Director		218-24-1840	Sex 7. Age 11 M 2 F	(In yrs. last 78	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Apr. 1	rth ay, Ye <i>ar)</i> 8 , 1931	9. Birth Cou Ma	place (State or Foreign ntry) ryland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation					10d. Inside City Limits	
	daryli f sho	ō	Marculand	Carroll			New Wind	deor				1 X Yes 2 □ No	
	the 28a-	Director	Maryland 10e. Street and Number	Carlott			10f. Zip Code		1	10g. Citizen o	Citizen of What Country?		
	3a or	<u></u>	2839 Carlisle D	rive				21776		U	U.S.A.		
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	o- 14. R	ace - Ameri		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tall Hygiene. So other than "natural", or items 23a or 28a-f show event, I've Madical Evaining must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? 1 XYes 2 Note 1	0		Yes 2 No		Mican, etc.)	Spec	ack, White,	nite	
5	72 h 'natu	Completed	15. Decedent's (Specify only highest g	Education trade completed)	10	6a. Deced (Give	lent's Usual Occup kind of work done	oation during most of work	dng	16b. Kind of	Business/In	dustry	
121	within ene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+				during most of work		acmor	+ ~		
22	e filed w al Hygie other t vent, th	ပိ	17. Father's Name (First, Middle, Las		C	ıynam	iter, re	pairman,			nt co.		
and	permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 Is marked ott any Injury or other traumatic ever once.	Be	Edward Haines	54/				10. Wouler's Ivail		Weller	,		
Ē		မ	19a. Informant's Name/Relationship	(Type Print)	1	Oh Mailin	a Address (Street	and Number or Ru				n Code)	
Ma			Denise A. Hernan				Box 343			je, MD 2		, 2000)	
altimore,			20a. Method of Disposition		20b. Place ceme	of Dispos	sition (Name of natory or other place	ce)	Date	20c. Location	1 - City or To	own, State	
<u>m</u>			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1		View Cem		/2009	Union	Brid	ge, MD	
alt	permit. Departr Importa any Inju		1. Signal re of 9 uneral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home										
<u>m</u>	207 2 2		Carraver (J. Harl	ar_	i.	6 E. Bro	adway U	nion Br	ridge, N	1D 217		
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	y one cause on each line	Э.		·					Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition resulting in death) a. Onset and Death Onset and Death Onset and Death Onset and Death										
-	/Medical Examiner		resulting in death)	Due to (or es e	consequenc	ce of):							
		ē	Sequentially list conditions,	b. Due to (or as a	OUNDEANHER	te afi							
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00 0	concoquant	JC 31).							
Ć.	ertificate be executed ling physician and e as the burial-transit	Exa	that initiated events resulting in death) Last	C Due to (or as a	consequence	ce of):			· · · · · · · · · · · · · · · · · · ·				
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89	rtifica ng ph as th	Jed	I SERVALE.										
.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Petal de	ath 3⊑	Ectopic pregnand Other (specify) _	ру			Date of deliv Month	very Day Year	
σ.	s that ned b deta	y Pr	Part II. Other significant conditions	contributing to death but	not resulting	g in the ur	nderlying cause giv	ren in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?	
rds	w requires t s been signe s should be	g p							12	Yes 2 □ No	3∏ Pro	bably 4 🗆 Unknown	
ပ္ပ	aw rec is bee	Completed							24a. Wa		o. Were aut	opsy findings available	
Ä	siclan: The law s certificate has t irector, page 2 s	E O							auto perf 1 □ Yes	opsy ormed2 2 No	death?	ompletion of cause of	
ita	lan: artifica ctor, p	BeC	25. Was case referred to medical examiner?	L				26. Place of Dea				20110	
<u>~</u>	Physic this ce al direc		1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 🗆 ER/	Outpatien	t 3 □ DOA Oth	ner: 4 Nursing H	ome 5 ☐ Res	sidence 6 🗆 C	ther (Spec	ify)	
Division of Vital Records,	ding Pl After th funeral	uo U:	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day)	y 28t Year)	o. Time of Injury	Wor	k?	28d. Describe	how injury occ	urred		
sio	tendi eath. ior: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	he				Yes 2□No					
Ξ	l or Attencatter death Director:	Certification: To	4 ☐ Homicide determine		ry - At home, (Specify)	, tarm, stre	et, factory, office		28t. Location City or To	(Street and Nur wn, State)	nber or Rur	al Route Number,	
_	spital ours seral filled		29a. Certifier 1 Certifying	Physician: To the best o	f mv knowled	dae, death	occurred at the ti	ime, date and place	and due to th	e cause(s) and	manner as	stated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Ex-	aminer: On the basis of and manner stat	examination	and/or inv	estigation, in my	opinion, death occu	rred at the time	, date and plac	e, and due	to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier		2		29c. Licens	se number		29d. Date sign	ned (Month	, Day, Year)	
			1 Thankon (Nay	-mD		000	55552	No.	7/6	109		
			30. Name and address of person wh	o completed cause of de	ath (Item 23	a) (Type, I	Print)	, , , ,		11		1	
			COURISIMANA	C- WACH	ans	- 70	DA POU	10 Kd	(LES)	m/w STA	KI	110 2115/	
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registra	r's Signature	bar	Lend					n Day, Year)	
	ricgion		JOE O 1 TOO	- Maria	1-1	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 3.50 PM George A. Howell 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimone Rosedale mane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 → M 2 □ F 214-12-3033 89 June Director 23,1920 Usual Residence of Decedent 10a. State MD filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Baltimore Essex 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 8620 Kelso Drive 21221 USA ns 23a must b Funeral than "natural", or Items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐¶Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify þ Specify: White Baltimore, Maryland 21215-003 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 is marked other ths any injury or other traumatic event, the once. Beth Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephus Howell Ada Bowers ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Riley /daughter 1511 Chivalry Court Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore MD 7/6/09 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Fu, eral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ona disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached it ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s performed To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000

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State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 2, **Physician** 2009 2:55 P M HINEGARDNER FRANKLIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 4, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1916 Months Davs Hours West Virginia M 2□ F Director 93 <u>233-22-0698</u> Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evanings must be notified at 1 □Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 318 Catherine Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Burner Technician Fuel Company is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Bly Allen Earl Cameron Hinegardner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau 200 H Thames Way, Bel Air, MD 21014 Ron Hinegardner / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Bel Air Memorial Gdn | 7-7-09 Bel Air, Maryland Funeral Service Licenses More and defess leady Home, P.A. 50 W. Broadway, Bel Air, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** 10 cardio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (as a consequence of) Examine Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No ed by the detached a∏Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner?
1 1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide . hc. .an 24 hours >e Funeral Dire > filled ir 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2

To the I

completed 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0066035 2.M.D. 500 Upper Chesapeake Or. Bel Aigmo 21014 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Denve B. parls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla		artment of rtificate of	Health and <i>Death</i>		giene Reg. No. 2 ()	ng	2151.1.
			Decedent's Name (First, Middle, in the control of the control	ast)					2. Date of Dea	ath	Voor	3. Time of Death
	iysicia Medic			Lı	ula Eli	izabeth	Hoffman		June	29 200	Year 19	9:29 P M
	camin		4a. Facility Name (If not institution,	ive street and n	umber)		4b. City, Town,	wn, or Location of Death 4c. County of Death				_
			Gilchrist Nursi	ng & Rel	hab Ctr		Tows		D. D. L. of Dist		imore	_
	neral ector		5. Social Security Number 218–14–7713	.Sex 1 □ M 2 🙀 F	7. Age (In ye	rs. last birthday) Yrs.	Months Days			y, Year)	Count	ace (State or Foreign ry) 1and
	ctor		Usual Residence of Decedent		91				April	ا 1910 و 1	rary	rand
yland	10		10a. State 10b. County		10c.	City, Town or Lo	cation				10	d. Inside City Limits
e Mai	g	cto	Maryland Ba	1timore				Dunda1k				1 □Yes 2 X No
it it	DE DE	Director	10e. Street and Number 206 South Woo	J 11 D.	and		10f. Zip Code			10g. Citizen of W		
sath v	Turst	eral			cedent Ever in	110 123	2122		Specify Ves or No	United	State - America	
-0036 hours after death with the Maryland hural" or items 23a or 28a-f show	event, the Medical Examiner must be notified at	by Funeral	11. Marital Status1 Never Married 2 Married3 Widowed 4 Divorced	Armed F	Forces? 2 ☑ No Give		was becedent of If Yes, specify Cul 1 ☐ Yes 2X No	Hispanic Origin? (pan, Mexican, Pue Specify:	rto Rican, etc.)	Black Specify:	k, White, e	
215-003 thin 72 hours a le.	ical E	ted	15. Decedent's	Education	n	16a. Dece	dent's Usual Occu	ipation during most of we	arkina I	16b. Kind of Bu	siness/Indi	ustry
d 21215- filed within 72 Hygiene.	Med.	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	ed)	iking	Tave	rn	
led wit	S.	ပိ	7 Years 17. Father's Name (First, Middle, La	-41			Barmaid	18 Mathar's No	me (First, Middle,			
iryland 2 thould be filed and Mental Hygi	ever	Be	John Hoffman	Si)				Lula			<i>5</i>)	
v 5 0 0	raumati	은	19a. Informant's Name/Relationship Marie J. Hoffma		r In La			at and Number or F odwell Ro		er, City or Town, alk, Mar	State, Zip	^{Code)} 21222
Hear Hear	theri		20a. Method of Disposition	11 (01300				-,	Date	20c. Location -	City or Tov	wn, State
altimore, rmit. Pages 1 au partment of Hee	y or o		1 Burial 2 ☐ Cremation 3				osition (Name of matory or other plants of Cemetel		2/2009		-	Maryland
Baltimor permit. Pages Department of	injur.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature Funeral Service Lice			A 2'	Name and Add	ace of Facility	•		_	
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peq	ısit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	o (or as a cons	sequence of):						
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58 / 60, ficate be executed physician and	the burial-transit	<u>a</u>		d	,							
68 / tifficate		edical		u,								
. Box t death certif e attending	nse	M/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pre-		☐ Ectopic pregnar	nev			e of delive	
C. C	ed for	Physician/Me	in the past 12 months? 1 □ Yes 2 No		gnant at time		Other (specify)			Mo	nth	Day Year
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Hecords, P.O. he law requires that the e has been signed by th	pe o	þ	Part II. Other significant condition	s contributing to	death but not i	resulting in the u	inderlying cause g	iven in Part I.	1	0. 4		ably 4 ☐ Unknown
as t	e 2 sho	Completed							24a. Was	an 24b. V	Were autop	psy findings available npletion of cause of
#	page	E O							perfo 1 □ Yes	rmed? c	death? I □ Yes	
VITAL Sician: The certificate	ector,	Be (25. Was case referred to medical examiner?	Harrison in the last					eath (Check only o			
Physi Physi	aldin	٦.	1 ☐ Yes 2 No 27. Manner of eath		Inpatient 2	ER/Outpatie	nt 3 🗆 DOA		Home 5 Resi	dence 6 Noth	er (Specify	NOSPILL
ding Affer	fune	tion	1 Matural 5 ☐ Pending	(Mo	onth, Day, Year		W	ork? □Yes 2□No	Zou. Describe	now injury occurr	eu	
DIVISION OT I or Attending Phy after death. Director: After this	in by the	Certification: T	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no determin	t ho	ce of Injury - A ding, etc. (Spe	t home, farm, str ec <i>ify)</i>	reet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,
To the Hospital or Attending Physician: within 24 hours after death.	ely filled		(Check only 2 Medical Ex	caminer: On the	basis of exam	knowledge, deat	th occurred at the	time, date and pla	ce, and due to the	cause(s) and ma	anner as s	tated.
thin 2	тре	Medical	one) 29b. Signature and title of certifier		inner stated.			nse number	· · · · · · · · · · · · · · · · · · ·	29d, Date signed		
5 ≥ 5	8		200. Signature and title of certifier	Lan			1	5830	3	1-100	200	
,		}	30. Name and address of person w	no-completed co	use of death /	Item 23a) (Tupo	Print)		/	1000	/	2009 NSEN MD
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	Sta		31. Date filed (Month, Day, Year)	000 32	Registrar's Si	gnature	4 !			-		

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			State of Marylar	nd / Depa	rtment of H	lealth and l	Mental Hy	giene	
		•	1 - State Registrar	Cer	tificate of I	Death		Reg. No. 2	9 2 5 4 5
100	Dhoolel		Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Yea	
	Physicia /Medic	- 4	Mark Duane Harris				June	28, 2000	
Š	Examin	er	4a. Facility Name (If not institution, give street and number)		- 41	r Location of Deatl	h	4c. County of D	eath
			University of Mary land Medical Center 5. Social Security Number 16. Sex 7. Age (In yrs	s. last birthday)	Ba Hiw If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th 9.1	Birthplace (State or Foreign
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ı.			Usual Residence of Decedent				10001		
	how at		Total State	City, Town or Loc	cation	Fecore			10d. Inside City Limits 1 ☐ Yes 2 No
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	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What United S	·
	s 23a nust	Funeral	1721 Hilltop Avenue	118 13 1	2122 Was Decedent of H		Specify Yes or No		American Indian,
	item item	Į,	Armed Forces?	l If	f Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, W	Vhite, etc.
39	urs af	3	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	1□ Yes 2□xNo	Specify:		Specify:	White
Maryland 21215-0036	2 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	oation during most of wo	rkina	16b. Kind of Busine	ess/Industry
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gu	be fill	Be	17. Father's Name (First, Middle, Last)				dy E. St		
ž	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	၉	Joseph L. Harris 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	na Address (Street			per, City or Town, Stat	te, Zip Code)
Ma	Pages 1 and nent of Health int: If Item 27 iry or other t		Mrs. Trudy E. Cook (Mother)	1721	Hilltop	Avenue	Essex,	Maryland	21221
ľe,	s 1 ar f Hea ftem other	1 4	20a. Method of Disposition 20b.	Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
Baltimore,	Page nent o nt: If	1	1 XBurial 2 Cremation 3 Removal from State	=	dge Mem.	1	/3/2009	Elkridge	e, Maryland
alti	permit. Departri Importa any Inju	1 3	21. Six ature of Funeral Service Licensee	22	2. Name and Addre	ess of Facility	1 Home o	of Dundalk	. Inc.
<u> </u>	9 9 E 8 9	1	Man C. Call		7922 Wise	Ave. T)undalk.	Maryland	21222
В			23a. Part1 Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
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1	/Medical Examiner		Due to (or is a conse		1 0 +	: Chack			Iday
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Вох	death certific e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregnanc	су		23d. Date of Month	
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or Vital Records,	uires sign lid be	d by					1 🗆	Yes 2No 3	☐ Probably 4 ☐ Unknown
CO		Completed					24a. Wa	s an 24b. Wei	re autopsy findings available or to completion of cause of
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ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place of De	eath Check onl		
<u> </u>	S S	101	1 Yes 2 No Hospital: Inpatient 2	ER/Outpatier	III 3 DOA			sidence 6 Other	(Specify)
L C	ing P After t unera		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)		Wo		0	e how injury occurred	t trailer
Sio	Attending r death. ector: Afte oy the fune	cati	2 Accident investigation Sunce 21 3 CCC		WYI	Yes 2X No	28f Location	-	or Rural Route Number,
Division	or A after d Direct	Certification:	3 Suicide 4 Homicide determined 28e. Place of injury - At building, etc. (Spe	ecify)	reet, lastory, emec		City or T	ocky point R	and Boltimore MD
_	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	a C	29a Certifier TX Certifying Physician: To the best of my k	knowledge, deat	th occurred at the	time, date and pla	ce, and due to th	e cause(s) and mann	er as stated.
1	the Ho hin 24 h the Fui npletely	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	ination and/or ir	nvestigation, in my	opinion, death oc	curred at the time		
Ψ	To the To the Complex to the	M	29b. Signature and title of certifler	11	29c. Licen	se number		29d. Date signed (A	Month, Day, Year)
			Mulchos N	VIZ	De	06 d6 T		shine 2	5, 2004
			30. Name and address of person who completed cause of death (II			21201	Al	Tabatak	ai M.D
7	C+	ate	31. Date filed (Month, Day, Year) 32. Profestrar's Sig		MD	21001	1 10	,	
	Regist		HH 0 17 0000 A	1	la Val				

DHMH 17 Rev 1/2001

/Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event; Its Madical Eventries must be notified at agines.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please	Type or Print					_		_		
1 - For State Registrar	State of Ma	-		rtment of r tificate of		a Mental H	ygiei Reg.	0000	21546	
Decedent's Name (First, Middle, Last	st)		-		-	2. Date of I		402 0 0 D	3. Time of Death	
Kenneth E.	,					July		Day Year 2009		
4a. Facility Name (If not institution, giv 8731 Valleyfie				4b. City, Town, o				4c. County of De		
5. Social Security Number 6. S		(In yrs. last birti	h day d	If Under 1 Year	erville		Divide.	Baltim		
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Usual Residence of Decedent		10 - C'I - T		- 41					Lancia di Li	
MD Balti	1	10c. City, Town Lu		rville					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
10e. Street and Number				10f. Zip Code			10a	Citizen of What (Country?	
8731 Valleyfiel	d Road			210	93		.og.		S.A.	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.										
1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🕱 No If Yes, Give)							White	
15. Decedent's Ed	Year or Dates:	16a.	Deced	ent's Usual Occup	pation		16b	Kind of Busines	s/Industry	
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	1 .		kind of work done PO NOT use retire Instrum			Ι,	Medical	Instruments	
17. Father's Name (First, Middle, Last)		3611	101	1113 CT CI		Name (First, Midd			This or differences	
Claude	Hare					garet	•	,	ilson	
19a. Informant's Name/Relationship (Vivian G. Hare-wi	* .					r Rural Route Nur L., Luthe		-	, Zip Code) 21093	
20a. Method of Disposition	16			ition (Name of	i i i i i i i i i i i i i i i i i i i	Date		Location - City of		
1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Dulane	y crem. y V	alley	^(ce) 7	7/10/09	1	imonium,		
21. Signature of Funeral Service Licen	See William (G. Dau	22.	Name and Address 1050 Yor	ss of Facility R	uck Tows Towson,	on F MD	uneral 21204	Home, Inc.	
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to one cause on each line	he death. Do n	-						Approximate Interval Between	
Immediate Cause (Final disease or condition	17.	reatic		Cancer					Onset and Death	
resulting in death)	Due to (or as a	consequence o		- 1,000					97,50	
Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence o	f):				_			
Cause (Disease or injury that initiated events	0	30,100 400,100 5	.,.						3	
resulting in death) Last	Due to (or as a	consequence o	f):		-					
	d									
IF FEMALE:	23c. If yes, outcome of	fprognancy								
23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death		Ectopic pregnand Other (specify) _	Э			23d. Date of d Month	lelivery Day Year	
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown		-	Other (apouny)						
Part II. Other significant conditions of	ontributing to death but	not resulting in	the und	derlying cause giv	en in Part I.	23e. Di			to the cause of death?	
cype - 1/10	goetes 1	701117	-45			_ 10] Yes	2 1 √No 3 □	Probably 4 Unknown	
Coronary 40	tery Dise	95e					as an topsy rformed	24b. Were prior to death	autopsy findings available o completion of cause of ?	
25. Was case referred to medical	a SCULAN	V1509	50		26 Plans of 1	1 ☐ Yes	2 🗗		es 2 🗆 No	
examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Out	natient	3□DOA Oth	or:	Death (Check onl ig Home 5 ☑ Re		6 □Othor (C	200164)	
27. Manner of Death	28a. Date of Injury (Month, Day,	28b. Ti		28c. Injur	y at			ijury occurred	<i>зеспу)</i>	
1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		rear)	_j ui y		Yes 2 □No					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, fare (Specify)	m, stre	et, factory, office		28f. Location City or 7	(Street own, St	and Number or ate)	Rural Route Number,	
29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge,	death	occurred at the ti	me, date and p	lace, and due to to	he caus e, date	e(s) and manner and place, and d	as stated. ue to the cause(s)	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Alexander 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chen

29d. Date signed (Month, Day, Year)

1 - For State Registrar Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Nell Virginia **Physician** Jackson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 20 baltimore Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Jackson **Funeral** Months Hours 1 □ M 2 □ F 70 Jan 23 1939 Director 225-42-7865 Usual Residence of Decedent 10b. County 10c. City, Town or Location nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanninar must be notified at 10a State Baltimore MD Director NA 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Vingenia Street 21229 USA 146 S. Culver Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: þ 3X Widowed 4 □ Divorced Health and Mental Hygiene. tem 27 is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Nell College (1-4or 5+) Elementary/Secondary (0-12) Fork Lift Driver Distributor Company 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Knownad Vernell Howard Ella Jackson ပ 19a. Informant's Name/Relationship (Type. Print) Childreh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health & Important: If item 27 is any Injury or other tra Angela & Dexter Jackson 146 S. Culver Street Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify)

21. Sanato e of Funeral Service Licenses 7/11/09 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home West Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** monas disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and ise as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy 5 Other (specify) signed by the a 1∐Yes 2. ZNo O. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ una Cancel Completed hypothyroid Sion,

obstructive pulmoriary

28a. Date of Injury (Month, Day, Year)

and manner stated.

Ave

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☑ Ño 1 Tyes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

23d. Date of delivery

Day

Vear

Month

3. Time of Death

Birthplace (State or Foreign Country)

VA

10d, Inside City Limits

21215

Approximate Interval Between Onset and Death Z

1XYes 2 No

0833 AM

Year

2009

14. Race - American Indian, Black, White, etc.

Specify: Black

Registrar

2435 W Bewerene 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Chronic

Be

ို

Certification:

Medical

this

After

within 24 hours after death To the Funeral Director: completely filled in by the

death.

è

Division Hospital or Attending 25. Was case referred to medical examiner?

1□ Yes 2☑ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

\$ 46 BALTIMORE 32. Pegistrar's Signature

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

068810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland / Depa <i>Cei</i>	artment of F rtificate of L			ene g. Noo o o o o	0151.0			
			Decedent's Name (First, Middle	, Last)				2. Date of Death	2000	3. Time of Death			
	Physicia		Jacob Richard J	acobsen				June 24,	Day Year 2009	8:15 P M			
ane.	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of Death				
		•	Hospice of the	Chesapeake		Harwood			Anne Arundel				
	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birthp Year) Cour	place (State or Foreign ntry)			
м	Director		577-40-8315	1 ⊠ M 2□F	77 Yrs.			May 17,	1932 Wash	ington DC			
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation			1	I0d. Inside City Limits			
	f sho	6		runde1	Harwood					1 ∐Yes 2 ½ No			
	28a-	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?			
	with Ba or	Ö	2112 Chesapeake	Harhour Dri	Ve.	21403			USA				
	ns 2:	Funeral	11. Marital Status	12. Was Decedent E		Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ				
ထ	or ite		1 ☐ Never Married 2X Marri	Armed Forces? 1 ★ Yes 2 ↑	DEE	if Yes, specify Cuba 1 □ Yes 2 🖾 No	n, mexican, Puerto Specify:	Mican, etc.)	Black, White,	etc. nite			
03	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show digat Event out to inclined at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	959	Tes ZENIO	opeony.		орослу.				
21215-0036	72 h 'natu	Completed	15. Decedent (Specify only highes	's Education et grade completed)	I (Give	dent's Usual Occup kind of work done of	turina most of work		6b. Kind of Business/In	dustry UN			
12	vithin sne. than '	E E	Elementary/Secondary (0-12)	College (1-4or 5-	+) _	DO NOT use retired							
2	iled v Hygie ther t		17. Father's Name (First, Middle, i	l ast)	Home	Construct		e (First, Middle, M	aiden Surname)				
an	d be fantal	Be c	Edwin C. Jacobs				Elizabet	h Mack					
<u> </u>	2 should n and Me Is mark raumatic	ပ္	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, Zip	p Code)			
Š	alth a 27 is r trai		Jane Jacobsen/w		2112	Chespeake	e Harbour	Drive A	nnapolis, M	ID 21403			
ē,	s 1 al		20a. Method of Disposition	_	20b. Place of Dispo cemetery, crea				Oc. Location - City or To				
Ę	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "ficial Event" or ust be notified an once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		a l	maiory or ourse pre-	-/						
Baltimore, Maryland			21. Signature of Funeral Service	Lice Wade, Jire	ctor 2	2. Name and Addre	ss of Facility	d 655 W.	Baltimore	Street			
m	Balle		Jenn 1	11/11/11/11	-	timora	Marulan	a 21201					
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
4	Physician	Immediate Cause (Final disease or condition											
	/Medical		resulting in death)	Due to (or as a	a consequence of):								
	Examiner	_	Sequentially list conditions,	b									
	sit sed	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	à contraquence di j.								
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c	a consequence of):								
68760,	be e sician buria				. ,								
587	ficate phys s the	edical		d									
×		N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	/ery			
. Box	death e afte d for I	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at		☐ Ectopic pregnanc ☐ Other (s <i>pecify)</i> _	у		Month	Day Year			
P.0.	t the by the	hys	9 Unknown	9 Unknown									
Š.	s tha gned e det	by P	Part II. Other significant condition	ons contributing to death bu	ut not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to				
ğ	en sig	ed						1 🗆 Ye	s 2 ½ 7No 3□ Pro	obably 4 Unknown			
ပ္ပ	law re as be 2 sho	Completed						24a. Was an	v prior to co	opsy findings available ompletion of cause of			
<u>۳</u>	The atte h	Som						perform 1 □ Yes 2		2 🗆 No			
/ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?					th (Check only one	9)				
$\frac{1}{2}$	hysl this c		1 ☐ Yes 2 🔀 No		ent 2 ER/Outpatie		4 LI Nursing H		nce 6 Other (Spec	ity) Hospice			
n	or Attending Physician: The law requires that the death cert lafer death card. Differ death of the difference After this certificate has been signed by the aftendin in by the funeral director, page 2 should be detached for use a	ion:	27. Manner of Death 1 Natural 5 ☐ Pendin		ry 28b. Time o y, Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred				
Sic	ttenc death stor: the i	icat	2 Accident investig 3 Suicide 6 Could r	not be 200 Place of Init	ury - At home, farm, st		Tes Z LINO	28f. Location (Str.	reet and Number or Rui	ral Route Number.			
Division of Vital Records,	after after Direction by	Certification: To	4 ☐ Homicide determ	building, etc	c. (Specify)	reet, lactory, office		City or Town	, State)				
	splta nours neral		29a. Certifier 1 2 Certifyin	ng Physician: To the best	of my knowledge, dea	th occurred at the ti	me, date and place	, and due to the ca	ause(s) and manner as	stated.			
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. Within 24 hours after death. After this certificate has been signed by the aftendir completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only 2 ☐ Medical one)	Examiner: On the basis of and manner sta	f examination and/or i ated.	nvestigation, in my o	opinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)			
	To the Hospital within 24 hours a To the Funeral I completely filled	ž	29b. Signature and title of certifie		^	29c. Licens	se number	25	9d. Date signed (Month	, Day, Year)			
			7. Helor	May M.C	١,	V	14838		6/2/2	JUY			
			30. Name and address of person	who completed cause of d	leath (Item 23a) (Type	Print) Das	table o	d Dini	mostic M	ud. 2140/			
			31. Date filed (Month, Day, Year)	32 Registr	ar's Bignature	no pai	0 00 - 10	ULL FJVIV	101-01-10				
	Sta Registr		JUL 0 7 200	9 Deven	ar's signature								

DHMH 17 Rev 1/2001

		Pleas	se Type or Pri							egible.	
		For State	State of M	laryland	•	irtment of I <i>rtificate of</i>	Health and I		jiene _{eg. No.} 2	000	2151.0
		Registrar 1. Decedent's Name (First, Middle,	, Last)			imodic or	Doan	2. Date of Dear	Death 3. Time of Death		
Physic /Med		JANICE	LEE	J	OHNSC	N		July	5. Day	Year 2009	8:10 A M
Exami		4a. Facility Name (If not institution,	, give street and number,	•)		4b. City, Town, o	or Location of Deat	ath 4c. County of Death			
<u></u>		1132 Splashi			s so irreto alos s d	Abingdo		8. Date of Birth		rford	lace (State or Foreign
Funeral Director		5. Social Security Number 220–40–9852	6. Šex 7. Ag	ge (<i>In yrs. l</i> asi	Yrs.	Months Days	Hours Min.	May 16	; Year)	Cour	vland
D		Usual Residence of Decedent						Thay 10	171		•
anylar show	=	10a. State 10b. County		10c. City, T	own or Loc	cation				1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
the M	Directo	Maryland Hart	ford	Ab:	ingdo	n 10f. Zip Code		1	Oa. Citizer	n of What Coun	
Z 15-UU30 thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show	Ö	1132 Splashing	a Brook Dr.			21009			USA		•
death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. V		Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14.	Race - Americ	
s after , or its	by Fu	1 Never Married 2 Marrie	ed 1 ☐ Yes 2 🔀 If Yes, Give	No		I∐Yes 2⊠No			Sp	necify:	
5-UUS6 72 hours aff natural", or		3 ☐ Widowed 4 🖾 Divorced	Year or Dates:		l6a. Deced	dent's Usual Occu	pation		16b. Kind	of Business/Inc	
	plet	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or		(Give)	kind of work done OO NOT use retire	during most of wor	king			,
C Z I Z I	Completed	12	, ,	, I	Admin	istrativ	e Assista			. Gover	nment
and be file ntal H ed oth even	Be	17. Father's Name (First, Middle, L						ne (First, Middle, I Mae Nee		rname)	
aryland should be fi and Mental I s marked of tumatic evel	မှ	William Lee Smi 19a. Informant's Name/Relationsh			19b. Mailin	a Address (Stree	nallie			own, State, Zip	Code)
and 2 sleath an 27 is ner trau		Melinda Johnson				•	ig Brook l		-	•	
es 1 a of He of He fitem		20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 Pamoual from State	20b. Plac	e of Dispos etery, crem	sition (Name of natory or other pla	nce)	Date	20c. Loca	tion - City or To	wn, State
altimor rmit. Pages partment of portant: If it y injury or o		4 □ Donation 5 □ Other (Sp	pecify)		Air M	lemorial	Gdn. 7-	11-09	Bel .	Air, Ma	ryland
Daltimore, Maryland Z.I. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic event, its		21. Signature of Funeral Service L	Jun CFS	PCPC	1 Mc	Name and Addr COMAS FU	ess of Facility Ineral Hor	ne, P.A.	16	D 21000	
		23a. Part 1. Enter the disease, or o	complications that cause	d the death.			bury Rd.	-		D 21009	Approximate
Physician		shock, or heart failure. List o	only one cause on each l	^	1 Ce	II Car	inuna			٤	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as	s a consequer		II Can	income				1100011
Examiner		Sequentially list conditions,	b								
uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	Due to (or as	s a consequer	ice oi).						
be executed cian and ourial-transit		that initiated events resulting in death) Last	C. Due to (or as	s a consequer	nce of):						
Attending Physician: The law requires that the death certificate be executed at death. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	lical		d								
X O X O Sertific Sertific Se as 1	Physician/Medica	IF FEMALE:	23c. If yes, outcome	e of pregnanc	v					t But of dollar	1
box death cer attendir f for use	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 Live birth	2 Fetal de	eath 3	Ectopic pregnan Other (specify)	су		230	d. Date of delive Month	ery Day Year
by the	hysi	9 Unknown	9 Unknown								
es tha igned be def	by P	Part II. Other significant condition	ns contributing to death t	but not resultir	ng in the ur	nderlying cause gi	ven in Part I.				ne cause of death?
w requires to been signed should be considered.								1 🗆 Y	es 21871	No 3 ☐ Prol	oably 4 ☐ Unknown
has by ye 2 sl	Completed							24a. Was a autop: perfor	sy	24b. Were auto prior to co death?	psy findings available mpletion of cause of
in: Th ifficate or, pag	ပ္ပ	25. Was case referred to medical					no Disease of Day	1 □Yes	2 No		2 □ No
ysicia is cert directe	0	examiner?	Hospital:	tient 2 EF	VOutpatien	nt 3 □ DOA Ot	hor:	ath <i>(Check only or</i> Iome 5 √⊘ Resid		Other (Special	fy)
ng Ph After th	L:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	jury 28 ay, Year)	Bb. Time of Injury	28c. Inju Wo		28d. Describe h			
ttendi death. der: A	icati	2 Accident investigated investigated as Suicide 6 Could not	ation of be]Yes 2□No	OOA Laantian (O		turning and Durn	J. Davida Aliverhay
l or At after of Direc	Certification: To	4 ☐ Homicide determin	nod 28e. Place of in	njury - At nome etc. <i>(Specify)</i>	e, tarm, stre	eet, factory, office		City or Tow	treet and f n, State)	number or Hura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C		g Physician: To the best Examiner: On the basis and manner s	of examination							
To the within To the compli	Me	29b. Signature and title of certifier	-C 0				se number		29d. Date s	signed (Month,	Day, Year)
,		pers	other.	~~~		D900	070200		7/	6/09	
GV		30. Name and address of person w	^ :	death (Item 2	3a) (Type, I	Print)	+. #400	Aberd	02.7 V	1) Z (c	00
St	ate	31. Date filed (Month, Day, Year)	32. Regist	trar's Signatur	e						8
Regist	rar	JUL 073	2009 Senen	~ 1	ba	Med					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State		ryland / Depa	rtificate of L			0000	01000
	Registrar 1. Decedent's Name (First, Middle,	Last)		- Incate of E	- Jean	2. Date of Dea		3. Time of Death
ysician Medical	Gertrude M	. Janos				June Month	Day Year 27 200	N.
miner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
	Charlestown R			Catons	ville If Under 24 Hrs.	To Date (Did	Baltimo	ore irthplace (State or Foreig
ral or	5. Social Security Number 6 217-09-4402	. Sex 7. Age 1 ☐ M 2 🂢 F	(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Feb. 9	y, $Year$)	Country) aryland
"	Usual Residence of Decedent					Teb. 7	, 1910 Me	
	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limi
Director	MD N/A		Balti	more City				1 ∑ Yes 2 □ N
ä	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
Funeral	4222 Shamrock	Avenue 12. Was Decedent E	ver in ILS 13	212 Was Decedent of Hi		pecify Yes or No	USA 14. Race - An	nerican Indian,
by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3XXWidowed 4 □ Divorced	Armed Forces?	0	Was Decedent of Hi If Yes, specify Cuba 1 □Yes ※XXNo	n, Mexican, Puerto Specity:	Rican, etc.)	Black, Wh	
Be Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occupa	ation	dina .	16b. Kind of Busines	s/Industry
l ble	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired	l)	ung		
ပ်	12th	2	Ban	k Teller	40.14.11.1.11	Cinna Baidella		rust Bank
Be	17. Father's Name (First, Middle, La Arthur Wunner	ist)					Maiden Surname) ehne	
은	19a. Informant's Name/Relationship	(Type Print)	19h Mailii	na Address (Street :	Gertri		er, City or Town, State	Zin Code)
	Timothy J. Wunn			2 Shamroc				21206
	20a. Method of Disposition		20b. Place of Dispo cemetery, crei			Date	20c. Location - City of	
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			eemer Cem.		2009	Baltimore	e, MD
once. To Be Completed by Funeral Director	21. Signature of Funeral Service Lie	Funeral H						
	23a. Part 1. Entur the disease, or co shock or eart failure. List or	omplications mat caused	the death. Do not en					Approximate Interval Between
1	Immediate Cause (Final diseese or condition	-a COP	D					Onset and Death
al er	resulting in death)	Due to (or as a	consequence of):					
	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	a consequence of):					
Examiner	cause. Enter Underlying Cause Disease of Injury that initiated events		,					
	resulting in death) Last	Due to (or as a	consequence of):					
edical		d						-
Med	IF FEMALE:							
Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. if yes, outcome of	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	у		23d. Date of d Month	lelivery Day Year
ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 51	☐ Other (specify)				
l f	Part II. Other significant condition	s contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
d by						1 🗆 `	Yes 2 □ No 3 □	Probably 4 Unkno
Completed						24a. Was	an 24b. Were	autopsy findings availa
l mo						autor perfo 1 □ Yes	prior to primed? death' 2 ☑ No 1 ☐ Yo	
Be	25. Was case referred to medical examiner?				26. Place of Dea			
	1☐ Yes 2☑No		nt 2 ☐ ER/Outpatie		4 Nursing H		dence 6 □Other (Sp	pecify)
ü	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time o (<i>Year)</i> Injury	Work		28d. Describe	how injury occurred	
Certification: To	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 200 Block of Inju	ry - At home, farm, str . <i>(Specify)</i>		Yes 2 □No	28f. Location (: City or To	Street and Number or wn, State)	Rural Route Number,
Medical Ce		Physician: To the best of caminer: On the basis of	examination and/or in					
		and manner sta	tea.	29c. License	e number		29d. Date signed (Mo	nth. Day, Year)
Mec	29h. Signature and title of certifier							, , , , , , , , , , , , , , , , , , , ,
Mec	29b. Signature and title of certifier	1.	26			-	T -	2
Medical Certifical	July me	no completed cause of de	and the filters 22st / Time	D 3	P8P0X		June 25 October	3 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** Helen 8:17 PM Fabian Junggust July 3, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2X F 50 213-78-8530 May 27, 1959 Director D.C. Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State es 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 23a or 28a-f show fi item 27 is marked other than "natural", or items 23a or 28a-f show to other traumatic event, it is five item it is not included. 1X Yes 2 □ No Director Prince George's Laure1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6942 Scotch Drive 20707 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐**X**Io Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 If Yes, Give Maryland 21215-0036 White 1 □Yes 2 DXNo Specify: Completed by 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Bartender 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Albert Fabianich Clements Mary Eleanora ည Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Danielle Jungqust / Daughter 7414 Sealawn Drive, Springhill, FL 34606 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition = 5 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page:
Department of Important: If any Injury or once. Ardent Crematory 7/6/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Dorota Marshall 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Multiple Injuries 17 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ANTELLIFE I PROPERTY IN requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 212 No 3 ☐ Probably 4 ☐ Unknown Hepatitis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an law certificate has page 2 autopsy performe e Hospital or Attending Physician: The 24 hours after death. 24 hours after death. E Funeral Director; After this certificate hietely filled in by the funeral director, page 2 🗆 No 1 ☐ Yes 2 X No 1 ☐Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1∰ Yes 2 ☐ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Driver in Motor Vechicle Accident
28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Natural 5 Pending investigation 06/17/2009 3:55 1 ☐ Yes 2 XNo рм 2 X Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 500 Hilton Parkway, Baltimore Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the F and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 James Henry Kinlein 05, 8:35 P. M July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Parkville 7711 Chestnut Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 09, 1952 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 M 2□F Months 57 Baltimore, MD. 217-60-3411 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2X No Parkville Director Maryland | Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 United States 7711 Chestnut Ave. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Žves 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify White Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Mildred Burton Michael Andrew Kinlein, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21162 Mrs. Diane M. Gilliam (Sister) 11322 Red Lion Road White Marsh Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State July 08, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 23a. Pary Enter the disease shock, owners had use. Immediate Couse (Final disease or condition resulting in death) elsease, dr.complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death PULMONARY OBSTRUCTIVE CHRONIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed burial-tran physician the attending pl for use as t been signed by the should be detached Hospital or Attending Physician: director, within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the F

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

C. VERGARA-SOARES 31. Date filed (Month, Day Year)

29b. Signature and title of certifier

6 ☐ Could not be

determined

cuasons MD

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D16619

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9940 FRANKLIN SQUARE DR. NOTTINGHAM M.D. 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Year 1. Decedent's Name (First, Middle, Last) 10 Month **Physician** therive /Medical ann 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner i DdA BAI n/a Timore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7, Age (In yrs. last birthday 5. Social Security Number 6 Sex **Funeral** Min. 1 M 2 1 Months Days Hours July 19, 1933 Maryland Director 212-30-9402 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the M. dical Examiner must be r 21030 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked ol Matilda Cooper Martin Mattisz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1406 Ivy Hill Road, Hunt Valley MD permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. George J. Kaff1/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 7/5/09 5 Other (Specify) Atlantic Crematory Glen Burnie, Maryland 4 □ Donation 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clary Approximate Interval Between Onset and Death 23a. Part1. Ent the di shock, r heart fail death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ease, or complications the caused each lin Immediat Cause (Final disease o condition resulting in Teath) 1 molh **Physician** /Medical Due to (or as a consequence of) Examiner Jer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying consequence of) Due to (or a./ Examiner that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician for use as the buria 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**⋈** № 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA ို After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: al or Attending P s after death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) 30 Name and address 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Day,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day William G. Lehrl 2:25 P. M July 4 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Lorien Mays Chapel Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/23/1921 5. Social Security Number 7. Age (In yrs. last birthday) Days 1√2√M 2□ F 37^{Yrs.} Maryland 213-16-9967 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Baltimore Timonium 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 12103 Tullamore Court #104 21093 f America 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1- Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2,5 No Specify: white 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Lehrl Natalie Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) 12103 Tullamore Ct. #104 Mrs. Rose Mary Lehrl/ wife Timonium, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition p Burial 2 ☐ Cremation 3 ☐ Removal from State Mays Chapel Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility. Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) ere Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Ot 25. Was exam 1 🗆 Y 27. Mann

Physician /Medical **Examiner** Examine

Physician

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be Welled within 72 hours after death with the h Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 any Injury or other traumatic event, the Medical Examiner must be notified once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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/Medical

physician and s the burial-tran attending properties of the second se After within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician/Medical

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Be Completed

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Certification:

Medical

29a. Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	cant conditions o	contributing to death but not res	sulting in the unde	erlying o	cause given in	Part I.		se contribute to the cause of death? √fo 3 ☐ Probably 4 ☐Unknown
							24a. Was an autopsy performed? 1∐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Was case referre	ed to medical				26.	Place of Deat	th (Check only one)	
examiner?	lo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🔲 D0	ome 5 Residence 6 Other (Specify)			
Manner of Death Natural Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, stree	t, factor	y, office		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RO79544

Retrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

TOW SUN, MYO 21204

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor

31. Date filed (Month, Day, Year)

6565 N. CHARLES ST. STE 4105 32. Pegistrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July ARCHIE DANIEL LILLY 5, 2009 AWM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Cherry Lane Nursing Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Director 233-30-8083 89 March 31, 1920 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 313 Montgomery Street 20707 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XXes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2KMarried Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: þ WWII 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electician Grade 10 Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levi Lilly Effie Meador ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Lilly son 313 Montgomery Street Laurel, Maryland 20707 Baltimore, 20b. Place of Disposition (Name of Columbia Primitive 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist Church Cem. July 7, 2009 Burtonsville, MD 21. Signature of Sumeral Tervice Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. (XC / M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ho ear as /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and be exec Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy The law requires that the death jo Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1□ Yes 2 2 certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zar nieres 31. Date filed (Month, Day, Year) JUL 0 7 2009 32. Registrar's State Registrar

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Name

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JUNE 2009 Ida Celia Lutz 29 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, 05–23–1927 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🗓 F North Carolina 82 243-26-9078 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notified at 1 X Yes 2 □ No Director Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. 1003 Woodson Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White <u>á</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Industry Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental I 7 is marked ot Be Alice Rabon Arthur Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) jes 1 and 2 s t of Health ar If item 27 is Owings Mills, Maryland 21117 5 Fairbridge Court Mr. Alexander A. Lutz, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entompment Moreland Memorial Park : 07/06/2009 Baltimore, Maryland 21. Signature of Funeral Service Aige 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. arles Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dadse on each line. Immediate Cause (Final **Physician** PHEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** LOYEARS HEONIC OBSTRUCTIVE PULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year for Month Day n signed by the a 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1XYes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. 7595459 All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7/4/2009 Day Year **Physician** 12:15P [™] Lee Friend Lindsey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville Fairhaven Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) 4/14/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Hours 134-01-2913 90 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show uny or other translab or 28a-f show uny or other tranmatic event, in Mendical Evanifue or 181 be retified at uny or other tranmatic event, in Mendical Evanifue. 10a. State Carro11 10d. Inside City Limits 10c. City, Town or Location MD Be Completed by Funeral Director 1 ☐ Yes 2 👿 No Mt Airy rederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Circle USA Belmont 6251 21771 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: USA 3℃XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Advertizing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Moise Immershein Adelaide Friend ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6251 Belmont Circle Mt Airy, MD John Lindsey / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 7/8/2009 Dulaney Valley Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204
Ruck Towson Funeral Home, Inc. 1050 York Road 21. Signature of Funeral Service Licensee uir 23a. Part 1. Enter the disease, or complications that was sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alzheimer **Physician** yeurs disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 □Yes 2. No Month Day Year of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ØNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this ical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersbug Jan Mid 1645 illian 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Wilfred J. Mottley 20059 12:15 P.M July 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Broadmead Cockeysville Baltimore 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs B. Date of Birth (Month, Day, Year) 1/29/1920 1 XM 2 ☐ F Months Days Hours 156-09-0066 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Cockeysville 1 ☐ Yes 2 ☐ No Maryland 10g Citizen of What Country? United States of America 10e. Street and Number 10f. Zip Code 21030 13801 York Road Apt. P12 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status NOTES: 10 No. If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 No white Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Facilities Manager American Cyanamid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Winifred K. Kane James P. Nottley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 Mrs. Teru M. Mottley/ wife 13801 York Road Apt. P12 Cockeysville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 7, Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2009 21. Signature of Fune al Service Licenses Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 79.71 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

the attending physician and hed for use as the burial-trar

has certificate

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completely filled in by the funeral director,

Certification: To

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Physician

/Medical

Examiner

Funeral

Director

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event, the Medical Examinar must be notified at

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Pages 1 and 2 should be filed within rent of Health and Mental Hygiene.

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The law requires that the death certificate be executed

Box 68760,

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Records,

Vital Physician:

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Hospital or Attending

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Baltimore, Maryland

Department of Health and Mental Hygic Important: If item 27 Is marked other any injury or other traumatic event, If once.

Examiner Physician/Medical <u>ک</u> Be Completed

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Tes 2 No

27. Mann Death

2 Accident

4 Thomicide

3 Suicide

29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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Vame	and address of	nerson who con	nnleted cause of	death (Item 23	a) (Type Prin

5 Pending investigation

6 ☐ Could not be

State Registrar

Hospital or Attending Physician: 24 hours a Funeral L completely

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Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, 2009

and manner stated.

Medical

(Check only one)

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 Norma Ethel MacDonald /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Burnie Anne Washington Medical Center len If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York . Age (In yrs. last birthdav) 8. Date of Birth Month, Day, Ye July 28, 5. Social Security Number **Funeral** Year) 1926 1 ☐ M 2 ☐ F Months Davs Hours 22-16-5941 82 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes ŽÍŽÍNo Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe than "natural", or items 23a or 21061 U.S.A. 217 Williams Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: White ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: if item 27 is marked other tha any injury or other traumatic event, it along. 12 Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ပ Charles Timbs Anna Alderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Bonnie Ladd / Daughter 1600 Severn Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral and Cremation Services, 1 2nd Ave SW Glen Burnie, MD 21061 116 M01220 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on such line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 1 ☐ 1 24a. Was an autopsy 2 1 No 1 □Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 40 Medical Certification: To 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

Refuneral Director: Aft olderely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one)

0 State Registrar 29b. Signature and title of certifier

30. Name

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29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's S

completed cause of death (127 23a) (Type, Pript)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 3:55 P JUNY 5, 2009 **Physician** Mary Emma MacDonald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Manor Care Towson Nursing Home 8. Date of Birth (Month, Day, April 2, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ F Pennsylvania 208-18-4769 89 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanters and the rectified at 1 ¥Yes 2 □ No Baltimore Maryland n/a Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 U.S.A. 6313 Falkirk Road Funeral within 72 hours after death 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 □No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ARA Service Catering 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t 2 should be fill the and Mental H. 7 is marked oth Be Cramer Darr Myrtle Hawk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) jes 1 and 2 s t of Health ar If item 27 is 6313 Falkirk Road Baltimore, Maryland 21239 Mrs. Wanda Maleski - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important: If it
any injury or o 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State July 9,2009 Baltimore, MD Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck Thc 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracerebral Hemor/hage resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1∐Yes 2⊠No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated within 2 To the I

State Registrar

North Charles 6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ORIGINAL

29c. License number

00061199

29d. Date signed (Month, Day, Year)

July, 6, 2009

St. Suite 4105 Tourson Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 04 200^{Year} рм 2:11 Morris Marguerite Μ. July 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year) Dec 20 1921 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 💢 F Yrs Georgia 87 415-30-5178 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □KNo Glen Arm Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21057 11630 Glen Arm Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 👿 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +4 Elementary/Secondary (0-12) Banking Head Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie M. McDonald Charlie B. Mathews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 Manor Knoll Court Baldwin, Md. 21013 Mr. Robert T. Morris, II/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-11-09 Timonium, Md. Dulaney Valley Mem. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final week disease or condition resulting in death) Due to (or as a Insequence of): Basterial prevmenia Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AVtery disease 2 1No 3 Probably 4 Unknown Chronico Schrotive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an disense Kidney disease 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 21 CE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. I 1 Natural 5 Pending investigation

/Medical Examiner be executed attending physician o this certificate Division of Vital funeral I or Attending Patter death.

Director: After 1 filled in by within 24 hours a To the Funeral D Hospital

Examiner Physician/Medical ģ Be Completed Certification: To

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

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Md.

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the "hadical Examinal must be notified at

72 hours after death with the Maryland

Pages 1 and 2 should be filed within

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th

Physician

21215-0036

Baltimore,

2 Accident

3 Suicide

29a. Certifier

Medical

4 🗌 Homicide

28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗌 No	28d. Describe how injury occurred
28e. Place of Injury - At he building, etc. (Special	28f. Location (Street and Number City or Town, State)				

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) Certifying Physician: It the best of my knowledge, death oest of cone)	pation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
Signature and title of certifier Mathy Mily, mo	29c. License number D 2 5 20 5	1017 4, 2009

6 ☐ Could not be

N. Charles St. Balto. Mid 2:20) 30. Name and address of person who completed cause of deat / Item 23a) (Type, Print) 6-BMC 6701

31. Date filed (Month, Day, Year) 7

Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) -PM **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number **Funeral** 10 yr. Min February 12, MaryTand 1926 1 □ M 2 🙀 F 219-16-5461 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "helical Even, in roust be nothing a 1X Yes 2 ☐ No N/A Baltimore Director Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21206 5914 Greenhill Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No Specify ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. item 27 is marked other than Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Palasik Jacob Kahler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 702 Beretta Way Baltimore Maryland 21015 Lawrence B. Miles, Jr./Son Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland 7/7/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leggiand Grand Road In Baltimore Maryland 21214 21. Signature of Funeral Service License ust 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer set and Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No After this certificate funeral director, pag 2 7 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2☑No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) icense numbe 29b. Signatu 20

State

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No/ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** : 00 ierzwicki arian 03 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner lizabeth N/A UNSING Lenter 8. Date of Birth (Month, Pay, Year) 6/22/1920 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Mary land 1 □ M 2 💢 F 214-14-9991 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Baltimore Directo MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21227 3300 Benson Ave Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry it of Health and Mental Hygiene.

If item 27 Is marked other than "natur or other traumetic event, Inc. Medical. 16a Decedent's Usual Occupation - 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Banking Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Kramer W. Simms Elijah ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Maryland 21409 990 St. Johns Drive Edward B. Mierzwicki, Jr /Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest, MD 7/13/2009 Garrison Forest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 1aryland 21204 Inc. 1050 York Road 22. Name and Address of Facility Towson, Maryland 21. Signature of Euneral Ser Ruck Towson Funeral Homé, 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final dow **Physician** re resulting in death) /Medical Dualo (or as a consequence of); Examiner ears emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): fibrillation To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted to the Funeral Director: WJ Exami attending physician and for use as the burial-tra-Division of Vital Records, P.O. Box 68760, e avs Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 5 Other (specify) n signed by the a ☐Yes 2 No 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2**X**1 No 3 Probably 4 ☐ Unknown inideuni icate has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No ension 111er 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0

State He gustran

31. Date file

30. Name and address of person who completed

, Day,

MD

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DHMH 17 Rev 1/200

use of death (Item 23a) (Type, Print)

Senson 32. Registrar's Signature

ORIGINAL

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Medinger 2009 Virginia Α. Ju1v а /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Timonium Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2√2 F 213-58-0028 94 Feb 17 1915 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If we did any Injury or other traumatic event, If we did any Injury or other traumatic event, If we did any Injury or other traumatic event, If we did any Injury or other traumatic event, If we did a second any Injury or other traumatic event, If we did not a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event, If we are a second any Injury or other traumatic event. 1 □Yes 2√2 No Director Baltimore Md. Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 1055 W. Joppa Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ∐Yes 21√2 No Specify: þ 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Ashley Mary Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 Mrs. Barbara Bowerman/ Niece 312 Morris Ave Lutherville, Md.Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-8-09 Druid Ridge Cem. Pikesville, Md. 22. Name and Address of Facility 21. Signature of Fungra Service Licer Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 □ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X) No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe IRGINIA 2 No 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSFICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oj

State

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31. Date filed (Month, Day, Year) 32. Rigistrar's Signa



RO TIMONIUM, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a & 328d maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 11:50p.[™] 2009 Sumantrai Naik July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F India 4-1-1933 Director 215-66-0455 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☑ No MD Funeral Director Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 Chatterly Court 21128 \mathbf{s} Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐Yes 2 No Specify Specify: Be Completed by White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gandabha Naik Vajiya 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra once. Son 3009 Benefit Court Abingdon, Md. 21009

| 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Ketan Sumantrai Naik Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/9/2009 BALTIMORE, MARYLAND GREENMOUNT CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Service Licenses 263 S. Conkling St. Balto, Maryland 21224 23a. Part 1. Enter the disease, co /plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If st our young cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 Z No 1 ☐ Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1¥Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation UNKNOWN 1 ☐ Yes しいというしい probable fall within 24 hours after death.

To the Funeral Director: A completely filled in by the fu in known 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide UNKNOWA 29a. Certifier (Check only Medical Examinet). On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Şignature-State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:54 AM 2009 2, July Joseph A. Perret /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F Yrs Feb 26, Pennsylvania 80 Director 193-20-4634 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examinational Department once. 1 ☐ Yes 2 X No Director Timonium Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21093 Funeral 2525 Pot Spring Road, unit 5603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: <u></u> White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Banking 02 Operations Specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Perret Mary ည Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Pot Spring Road, unit 5603, Timonium, MD 21093 Nancy S. Perret/Wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/6/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Memorial Gardens 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan Clary Approximate Interval Between Onset and Death 23a. Part 1. Enty the disease, or complications that caused the shock, of heart ailure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate rause (r nal disease or c and n resulting in death) **Physician** PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner r Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐ Yes 2∏ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director A 2 Accident n by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Exami completely within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

TOSEPH

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, -Year)

ORIGINAL

32. Restrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death 8:01 PM Month **Physician** MAGGIELENE INACLE 200 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Manyland Medical Center Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219-26-8266 1□ M 2 🕶 F Months Days Mary Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If New 23a or 28a-f show Important: If New 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is some Examine main to incline a 1 Nes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Mo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 □Yes 2 □No <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) echnician 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last, Rosie nac Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Battimore 21207 Granda Ave arandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 10r 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service License we 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reservatory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an performed?/ 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AU4176435T1970

State Registrar 2009 Fitz wavren flack,
31. Date filed (Month, Day, Year)

32. Regettar's Signature
32. Regettar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Jank

202,

Laila Tabatabai, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04980 State of Maryland / Department of Health and Mental Hygiene Rov E. Riley Certificate of Death _ 1- For State 2. Date of Death Registrar

1. Decedent's Name (First, Middle, Last) 0732 hrs Physician/ June 24, 2009 Roy E. Rilev Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 11 W. 20th Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreian **Funeral** Min Hours Months Davs Country) MD 7-14-1948 Director 60 Yrs 216-50-2533 1XXM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County È 1 X Yes 2 No Baltimore MD N/A or 28a-f show "natural", or items 23a or 28a-f shor Examiner must be notified at once. 10g. Citizen of What Country? death with the Maryland Director 10f. Zip Code 10e, Street and Number 21218 USA 11 W. 20th Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 2 X No Black Yes Yes 2 X No specify: Specify. 4 X Divorced If Yes. Give Year Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Disabled If item 27 is marked other than ' her traumatic event, the Medical Disabled 21215-0036 N/A 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Black Be Edward Francis Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ 21206 Dr_{Balto} Q 6050 Moravia Par Earl Riley -Brother Oc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place)
Greenmount Itimore, Burial 2 X Cremation 3 Removal from State 7-3-2009 Balto, MD Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee Balto, MD 1101 E. North Avenue 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** Death failure. List only one cause on each line Medical Methadone intoxication Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed events resulting in death) Last AMENDED 23a,27,28a-f,perME, g893 7/30/09 TT and Physician/Medical X UNPENDED ysician burial -23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760 IF FEMALE: Year phy the b 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth 2 use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknow After this certificate has been signed by the att funeral director, page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown Division of Vital Records, P.O. ğ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed No Yes 2 Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Nursing Home 5 Residence 6 ✔ Other: Scene Be Hospital: DOA examiner? ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28h Time of Injury 28a. Date of Injury 27. Manner of Death unk Yes 2 X No Certification: Fd 7:32 am within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural Fd 6/24/09 Pending 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11 W. 20th St Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident 6 X Could not be 3 Suicide Baltimore, determined

29a Certifier 1

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

INe 30. Name and address of person who completed cause of death (Item 23a)

07 2009

Medical

State

Registrar

32 Registrar's Signature Marko ORIGINAL

and manner stated

Assistant Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		C	Certificate of	Death		F	Reg. No.	2009	215/1
	Physicia	212	1. Decedent's Name (First, Middle, Las					2	Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al		hwalski		41. Cit. Tour	- Lastina	- Dooth	July	100	county of Deatl	
	Examin	er	4a. Facility Name (If not institution, give street and number) NW Season's Hospice			4b. City, Town, o	altim				Balti	
_	Funeral		5. Social Security Number 6. S	ex 7. Age (i	n yrs. last birth				. Date of Birth (Month, Day		9. Birt	hplace (State or Foreign untry)
	Director		212-02 6397	⊠ M 2□ F	56 Yr	s. Worth's Bays	Tiodis		March	18,1		MD
	and		Usual Residence of Decedent 10a, State									
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	h the	Director	10e. Street and Number			10f. Zip Code		-		10g. Citize	en of What Co	untry?
	23a c		304 George Av				21221			US		
	er de s items	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces? 1	r in U.S.	 Was Decedent of H If Yes, specify Cub 	Hispanic Ori an, Mexicar	igin? (Speci n, Puerto Ri	ity Yes or No- can, etc.)	1	4. Race - Ame Black, White	
036	irs aft	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2XINo <i>Specify:</i>					Specify: W	hite
Ž Ž	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, I're Medical Examinat must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	Decedent's Usual Occup Give kind of work done ife. DO NOT use retire	pation during mos	t of working		16b. Kin	d of Business/	Industry
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Σ,	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Marguarite Ry	chwalski /	/wife	304 Geor		venue Da			re MD	
altimore, Maryland 21215-0036	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3 ☐			Disposition (Name of crematory or other pla					•	
≝	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specification 21. Signature of Dineral Service Licer		HOLY .	Rosary Ce		_			ltimo	
Ba	Depi Impo any		Valor Tell	Cornell	0	22. Name and Addre	ollv	Funei	Mace ral Ho	Ave ome	of Es	sex 21221
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused th	e death. Do no	t enter the mode of dy	ing, such as	cardiac or	respiratory a	rrest,	<u> </u>	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition a Globa Standa Mu In ormo									
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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68760,	rtificate be executed ng physician and as the burial-transit	Medical		d								
9 X	± S, α		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						2	3d. Date of de	livery
P.O. Box	death ce e attendii d for use	Physician/	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су				Month	Day Year
<u>О</u> .	at the by the	hys	9 ☐ Unknown	9 Unknown					oos Dida	ab a a a a	no contributo t	o the course of death?
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_	hysici his ce I direc		examiner? 1 ☐ Yes 2 🔁 No	Hospital: 1 ☐ Inpatient		Datient 3 1 DOA					Other Sp	THOUS HOSPICE
Division of Vital Records,	ing P	ion:	27. Manner of Death 1	28a. Date of Injury (Month, Day,)	Year) 28b. Ti	ury Wo			8d. Describe	how injury	occurred	
isio	ttend death ctor: ,	icat	2						Street and Number or Rural Route Number,			
<u>≥</u>	al or A after I Direction by	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)				City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use		29a, Certifier 1 Certifying P	nysician: To the best of miner: On the basis of e	my knowledge, examination and	death occurred at the l/or investigation, in my	time, date a	and place, a	and due to the	cause(s) date and	and manner a	as stated. e to the cause(s)
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner state	d.	29c. Licer	nse number			29d. Dat	e signed (Mon	th, Day, Year)
	5 <u>¥ 6</u> 8		> LOW ALL ILL	Bull			593	j		July	1 2 70	009
	10 /		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type Print\		-		17	0 11	1.0
	In A		or usphie	Butten		5 Smill A	them	ue 8	rule?	203	Baltu	none MD
	Sta Registi		31. Date filed (Month, Day, Year)	32. Rigistrar	s signature	barker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3, 2009 DONALD NORRIS RYAN JULY 7:00 P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford 1504 Westminster Ct Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□ F Maryland Director 10, 1931 Aua. 219-36-0374 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Paglical Exp. items must be mailled at 1 ☐Yes 2 No Director Bel Air Marvland Harford 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1504 Westminster Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 ☐ Widowed 4 Noivorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene.

is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Computers Sales & Service Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be timent of Health and Mentatent: If item 27 is marked John Orville Ryan Olga Bier Wimmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 803 Meadow Lane, Palmer Lake, CO 80133 Donna R. Williams / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7-8-09 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 4317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Dav Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗆 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending ours after death. leral Director; Ai filled in by the fu 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital or 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOOL 6 31 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4:11 Corporate Center Dr. Abingdom 3445 E MU 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Benjamin Earl Runk State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month D. July 2, 2009 1850 hrs **Medical Examiner** Benjamin Ear1 Runk. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director June 16, 1971 Maryland 218-84-1173 38 1 X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits in, 10a. State 10b. County 1 X Yes 2 No 28a-f show Maryland 1 4 1 N/A Baltimore death with the Maryland Director 10g. Citizen of What Country 10f Zip Code 10e. Street and Number U.S.A. 4201 Doris Avenue 21225 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Never Married 2 Married Armed Forces? 2 X No Yes Yes 2 X No specify: Give Year Specify: White Widowed 4 Divorced riant: If item 27 is marked other than "natural" or other traumatic event, the Medical Framiers \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 l Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7. 12 N/A Food Service Manager Restaurant permit. Pages 1 and 2 should be filed withit
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bonnie Gettier Be Benjamin Earl Runk, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie E. Wyatt (Mother) 3920 Baltimore Street Halethorpe Maryland 21227 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 07/08/09 Glen Burnie, Maryland Donation 5 Other Specify: Name and Address of Facility
McCully—Polyniak Funeral Home, P.A.
237 Fast Patapsco Avenue Baltimore, Maryland 21225 21. Signature of Fuperal Service Licensee 23a. Per I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of chronic alcoholism and Approximate Interval Physician Between Onset and /Medical Death a hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ian/Medical #1 as noted, 23a,27,perME, g894 8/5/09 TT X AMENDED X UNPENDED attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Month Fetal death past 12 months? Pregnant at time of death Physici Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 ✔ No 3 Probably 4 Unknown Completed ncate has been s page 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has death? performed? No 1 🗸 Yes No Yes 2 2 the Hospital or Attending Physician: hin 24 hours after death. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 ✓ Inpatient 2 Residence 6 DOA Nursing Home 5 ER/Outpatient 3 1 V Yes 9 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Yes 2 No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 3, 2009 Jame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 62. Registrar's Signature 31. Date filed (Month, Day, Year) State 2009 Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 11:24 a.M. **Physician** 2009 obinson /Medical or Location of Death 4c. County of Death Fadility Name (If not institution, 4b. Examiner Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F Months Davs 313 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f shorother traumatic event, the Medical Examiner must be notified at 1 Nyes 2 No **Funeral Director** カかび 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21 20 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any Injury or other traumatic event, Inc. Media once. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maide Father's Name (First, Middle, Last) Be DINSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kobinson - Son 2103 ximule 221th Mole Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Foneral Service Licens 22. Name and Address of Facility HORL 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Un Known Arteriscleritie Vascular disease or condition resulting in death) Coronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 □ Yes funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed yes 2 1 ☐ Yes 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Lawrence Joseph Schaub, Sr. 1:20 A. 2009 July 4 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Atlantic General Hospital Berlin Worcester If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days 1⊠M 2□ F 19, 1918 90 Maryland Dec. 215-09-5724 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10304 Iron Gate Court 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 ☐Yes 2 🛣 No White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Management Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles F. Schaub Rose Marie Dressler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lawrence Schaub, Jr. Son 10304 Iron Gate Court; Ocean City,MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 7/8/2009 Elkridge, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee malsu Hudeman 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PSI Due to (or as a consequence of): In fection Tract rinar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consecute result Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown Lancer 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Pulmonay Disease Chronic obstructive 1 ☐ Yes 2 ZNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner STA sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 0 Hospital

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Funeral

Director

Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. Musical Examiner must be notified at any Injury or other traumatic event, it.

death with the Maryland

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Pages 1 and 2 should

Physician

/Medical

altimore,

Physician/Medical 2 Completed Be Medical Certification: To

29a. Certifier

3 ☐ Suicide 4 ☐ Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9733 Healthway

Berlin, MD 21811

29b. Signature and title of certifier

29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

SzymalaDO 31. Date filed (Month, Day, Year)

Atlantic General Hospital 32. Registrar's Signature

and manner stated.

Barke

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month July Day 2009 Year **Physician** 02, 12:27P.M Harry Gragg Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County 8945B Walthham Woods Road Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 12 M 2 □ F 39 West Jan. 11, 1920 Virginia 479-12-0608 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director Baltimore Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic event and increase. United States 21234 8945B Walthham Woods Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2⊠No Specify. White Completed by W.W.II 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Martin Marietta Engineer 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Gragg Moffett C. Smith ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type. Print) Perry Hall, Maryland 21128 Schroeder Ave. Mrs. Debra L. Mast (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 03, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Evans Funeral Chapel 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Parth. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive **Physician** YEGUS disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner VEGUS theroscleratio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy Month Day Por in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for P.0. □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Embilism ulmonar Completed 24b. Were autopsy findings available prior to completion of cause of death? hronic 24a. Was an hast page 2 s autopsy 1 ☐Yes 2 No Vementia certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MM

32. Registrar's Signature

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

57444

19099

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 200 Year 06° 12:35 A.M Ruth Anita Swinderman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1 ☐ M 2 🗗 F 86 219-18-6978 Feb. 25, 1923 Baltimore, MD. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Baltimore County Lutherville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21093 United States 1823 Blakefield Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No White Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie E. Wagner Richard Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Jules Brentony Court Cockeysville, MD. 21030 Mr. Charles Shaw, Jr. (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 07 Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BLADDER MONTHS Le to (or as a consequence of): Sequentially list conditions Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed burial-trar attending physician for use as the burial Box 68760. P.0. signed by the a Division of Vital Records, has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

ner Exami Physician/Medical Completed Be ၉ Certification:

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

"natural", or items 23a or 28a-f show

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s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th

permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other injury or other

Physician

/Medical

FOTH A. SwinderMar Baltimore, Maryland 21215-003

traumatic event, the Medical Examiner must be notified at

Medical

State Registrar

4 Homicide

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide

29b. Signature and title of certifier

29a. Certifier and manner stated.

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JULY 6. 2009

BALTIMORE, MO 2:204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANKUE DOBERMAN, MO 555 WEST TOWSON TOWN BLVD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** July 2, 2:47 AM Elsie Lillian Schafer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkville 3414 E. Joppa Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Co 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2√2 F 79 Director 216-24-9540 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show or than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Director Baltimore Parkville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 3414 E. Joppa Road Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ∐Yes 2 Man If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ XMarried Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than 'any Injury or other traumatic event, its Magnes any Injury or other traumatic event, its Magnes. Laundromat Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Wagner James King ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B414 E. Joppa Road- Parkville, Maryland 21234 Edward Schafer, Sr-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place St. Joseph Church 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fullerton, Maryland Cemetery

2. Name and Address of Facility 21. Six Tyre of Funeral Service Licensee 8800 Harford Road Parkville, Maryland 21234 EVANS FUNERAL CHAPEL AND CREMATION SERVICES -ondrae tudd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Year > 01 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abused and burial-transit Due to (or as a consequence of) P.O. Box 68760 After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) I □Yes 25No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2▼No 24a. Was an autopsy performed? I ☐ Yes 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31 Date filed (Month

air 1 T Reilterstown 21176

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last)

3. Time of Death

1 - For State Registrar

	Physicia /Medic		Howard Leroy Sheeler		July	4 2009	9:45 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
./			726 Warren Road	Cockeysville	9 Date of Birt	Baltimore	place (State or Foreign
	Funeral Director		5. Social Security Number 215-34-6333 6. Sex 1	Months Days Hours Min.	March	h y, Year) 9. Birthp Cour 21 1937	place (State or Foreign htry) MD
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Maryl f sho	힏	MD Baltimore Cockey	sville			1 ☐ Yes 2 🗙 No
	the 1	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cour	ntr y ?
	h with		726 Warren Rd.	21030		USA	
	ems a	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
320	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it is Medical Examination or critical at	by	1 Nover Married 2 Married 1 Tyes 2 Mg	1 □Yes 2X No Specify:			hite
215-0036	72 hou "nature Jicel E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working	ing	16b. Kind of Business/In	dustry
	within iene.	ш	Elementary/Secondary (0-12) College (1-4or 5+)	bo NOT use retired) k Driver		County Gov	vernment
יי ס	filed Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)		(First, Middle,	Maiden Surname)	
<u>lan</u>	uld be Vental Irked o	To B	Howard Leroy Sheeler Sr.	Addie	Marie	Baublitz	
		ľ		ing Address (Street and Number or Rura			Code)
e o`	s f and of Health item 27 other t			Warren Rd., Cock	Date	20c. Location - City or To	own. State
nor	di O				8/09	,	· —
	permit. Page Department Important: It any Injury o						
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	0		23a. Part 1. Enter the sease, or complications that caused the death. Do not en shock, or he in figure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
F	Physician		Immediate Cause (Fin 1 disease or condition resulting in de th) Probable acut Probable acut Probable acut	te myocardial	in face	ction	Onset and Death
i.	/Medical Examiner				JELES - J.		15
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	•			
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9	atten for us	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	Day Year
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ğ	aquire en siç ould b		Type II diabetes mellitus		1 🗆 '	Yes 2 □ No 3 □ Pro	bably 4 ☐ Unknown
ပို့	law re las be 2 sho	plet	Hypertension		24a. Was	osy 🛴 prior to co	opsy findings available empletion of cause of
	sician: The lav certificate has rector, page 2:	Completed	'			ormed? death? 2 ☑No 1 ☐ Yes	2 □ No
3 3	iysician: iis certific director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
o	Phys rthis ral dir	۱ <u>.</u>	1 Yes 2 No rospital: 1 Inpatient 2 ER/Outpatie 27. Mannayof Death 28a. Date of Injury 28b. Time of	ant 3 DOA 4 I Nursing Ho		dence 6 ☐ Other (Speci how injury occurred	fy)
ا ا	Attending Physician: It death. ector: After this certific by the funeral director,	ition	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation				
DIVISION	Atter	Certification:	3 Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of Injury - At home, farm, sti	treet, factory, office	28f. Location (Street and Number or Run	al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, dear (Check only one) 4 Medical ExamIner: On the basis of examination and/or in and manner stated.				
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) () () () ()	D0026575		7-07-20)09
	lov		30. Name and address of person who completed cause of death (Item 23a) (Type,				
	Ψ V Sta	to	David Hartig, M.D. 10155 York 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	Rd., Suite 200, C.	ockeys	ville, MD 210)30
	Sta Registr		JUL 0 7 2009 Sener B. 19	park			

			1 - For State Registrar	of Maryland / Dep	partment of Healtle		giene 009	21580
	Physicia	_	1. Decedent's Name (First, Middle, Last)	. Sinne	rs ·	2. Date of De Month	Day Year	3. Time of Death
À	/Medic Examin		Facility Name (If not institution, give street and	1 1 1	4b. City, Town, or Location 15al try	on of Death	4c. County of Deat	
	Funeral Director	4	5. Social Security Number 6. Sex 1 □ M 2 □ 1	7. Age (In yrs. last birthda	Months Days Hou	der 24 Hrs. 8. Date of Bir	th Year) 9. Birth Co	nplace (State or Foreign untry)
	iryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or				10d. Inside City Limits 1√2 Yes 2 □ No
	th the Ma or 28e-f)irecto	Maryland N/A 10e. Street and Number Considerable Consideration	Baltimo	10f. Zip Code		10g. Citizen of What Co	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or ttems 23e or 28e-f show event, I'm Medical Examinar must be notified at	by Funerai Director	1 Never Married 2 Married 1 Yes	Avenue Decedent Ever in U.S. 11 If Forces? es 2 🖾 No	21209 3. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 Yes 2 No Specify Cuban	ican, Puerto Rican, etc.)	14. Race - Ame Black, White	
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	e filed within at Hygiene. other than "	e Com	Elementary/Secondary (0-12) Unknown 17. Father's Name (First, Middle, Last)	ge (1-4or 5+)	Homemake:	Cother's Name (First, Middle	Own Home	
Maryland	should be and Mental is marked o	To Be	John R. Strickland			Margaret		7.0-41
Mar	nd 2 lith a 27 ls r tre		19a. Informant's Name/Relationship (Type, Print) Springwell Senior Livi		ailing Address (Street and Nu 211 W. Rogers			
Baltimore,	Pages 1 and ment of Healt ent: If item 2' iury or other		20a. Method of Disposition	cemetery, c	sposition (Name of trematory or other place) Memorial	7/8/2009	20c. Location - City or Pikesville,	
Balti	permit. Pages Depirtment of Importent: If any njury or once.		21. Signature of Funeral Service Licensee	nss	22. Name and Address of F Burgee-Henss- 3631 Falls Ro	-Seitz Funera	al Home, Inc re, Maryland	. 21211
	Physician		23a. Part 1. Ent., the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	nat caused the death. Do not on each line.	enter the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	e to (or as a consequence of):	HISTOT FALL	LURE		VEARS
	ned nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of): ARDIO MYOP	ATHY			VENRS
68760,	ite be executed iysician and he burial-transit	ical Exar	that initiated events resulting in death) Last	to (or as a consequence of): TOTAD SCLORO	OTIC CARDIO	VASCULA R	Disense-	Ylmas
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	, outcome of pregnancy ive birth 2 D Fetal death regnant at time of death Inknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
Δ.	ires that the signed by doese	þ	Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause given in F	4.1.1	tobacco use contribute t	o the cause of death?
Vital Records,	The law requirate has been spage 2 should	Completed	CEICETTICOVASCALAIZ	7,001,0010		24a. Wa aut per 1 □ Yes	opsy prior to death?	utopsy findings available completion of cause of
Vital	sicien: certifica rector.	o Be Co	25. Was case referred to medical examiner? Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpa	Other L	Place of Death Check on Nursing Home 5 - Re	one	
o	ng ffe ine		27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ ER/Outpa Pate of Injury Month, Day Year) 28b. Tim Inju	e of 28c. Injury at	28d. Describe	how injury occurred	iony)
Division		Certification;	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e.	Place of Injury - At home, farm building, etc. (Specify)		28f. Location	(Street and Number or Flown, State)	lural Route Number,
)	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medicai Ce	(Check only 2 Medical Examiner: On t	o the best of my knowledge, d he basis of examination and/o manner stated.	leath occurred at the time, da or investigation, in my opinion	te and place, and due to the , death occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	hip.	29c. License num D-1942	ber 25	29d. Date signed Mon	nth, Day, Year)
	2 1		30. Name and address of person who completed ROBURT E- ROBY	MD221/ U	Pe, Print	AVE - BALT	TMORE, M.	D 21209
À	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 0 7 2009	32. Redistrar's Signature	Sand			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** :36 AM Time 2000 1270 /Medical 4b City, Town, or Location of Death County of De 4a. Facility Name (If hot in stitution, give street and num Examiner red ica YNNE ALTIMURE 10 enter Birthplace (State or Foreign Country) Social Security Number Age (În yrs. last birthday Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M M 2 □ F 33 **Director** 216-04-0394 ecember 20,1975 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ∏Yes 2 No injury or other traumatic event, the Medical Examinar must be refilled Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 657 Willowby 21122 U.S.A. Run Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 █ If Yes, Give Year or Dates: 2 No or i 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other trainmant. N.E.I. Insurance Service Insurance Auditor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. Boteler George Schaum Peggy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kristine K. Schaum (Wife) 657 Willowby Run, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State June 30, 2009 Meadowridge Mem. Park Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lium diate Cause (Final sease or condition resulting in death) **Physician** /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Sh The law requires that the death certificate be executed OTIC attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Minpatient ဥ 1 ☐ Yes 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Date filed (Month, Day,

HPISTOPHER

Baltimore, Maryland 21215-0036

Box 68760

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of Vital Records,

Division

Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-05150 Ryan Edward Shaw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 21582

II EUWa	,, a O, i	1	- For State Certificate of Death		eg. No.	10.71
Ph	ysicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Dea Month	Day Ye	3. Time of Death ear 0920 hrs
	iysicia Examir		RYAN FOWARD SHAW	June 30,	2009	
Ç., <u>-</u>			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	ath	4c. County	
			107 Laurel Valley Court Abingdon		Harford	
_			5. Social Socurity Number 6. Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24H	Irs. 8. Date of Bi	rth (MM/DD/YY)	yy) 9. Birthplace (State or Foreign Country)
	neral ector		216-17-0072 1X M 2 F 28 Yrs. Months Days Hours M	Apr. 4	, 1981	Pennsylvania
Dire	ector			1-1-		
	*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	w any	- 1				1 Yes 2 X No
land	28a-f show d at once.	ō	Maryland Harford Abingdon 10f. Zip Code		10g. Citizen of	What Country?
Mary	28n-	Director	10e. Street and Number		1107	ì
the	s 23a or 28a-f shov e notified at once.		107 Laurel Valley Ct. 21009 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Chacify Ves or N	USA 14. Ra	ace - American Indian, Black,
with	ns 23	Funeral	11. Marital Status	erto Rican, etc.)		hite, etc.
leath	r iter	m	1 X Never Married 2 Married 1 Yes 2 X No		Specif	White
fter	l", o		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	ef week done	1	Business/Industry
urs a	amin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	retired)	Tob. rand or	,
72 ho	al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			3. 0
)36 thin	than dic	ldu	12 Owner/Operator	ame (First, Middle	Moiden Suma	d Service
5-0036 iled within 7	lygier other he M	ပ္ပြဲ	17. Father's Name (First, Middle, Last)			mo,
215 e file	Mental Hygiene. marked other than c event, the Medical	Be	LAWATA TAYMOTA BITAN	Ann Hei	Ctz	Town State Zin Code)
2121 suld be fil	Mer mar	2	Tod. Informatio Hamer Leave 1, 77			
MD rd 2 sho	h and 27 is mati	· ·	Sharon A. Shaw / Mother 2752 Parallel Path,	, Abingac Date	On, MD	21009 ion - City or Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland	ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ŕ
O C	it of l		1 Burial 2 Cremation 3 X Removal Holl Suith Crematory 7	7-2-09	Strou	udsberg, PA
tim F Pa	rtmer rtan y or		22 Name and Address of Facility	Home P	Δ	
Baltimore,	Department o Important: injury or oth	1	1/ May Van Algane / 1317 Cokesbury F	Road Ab	nadon.	Maryland 21009
		_	23a. Part I. Enter the disease, or many non-that caused the death. Do not enter the mode of dying, such as card	iac or respiratory	arrest, shock, o	r heart Approximate Interval Between Onset and
	sician ledical					Death
	miner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic and alcohol intoxication Due to (or as a consequence of):			
			b			
		l a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		틝	cause. Enter Underlying Cause (Disease or injury that initiated			
	=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Records, P.O. Box 68760,	and transit	1 2	MUNPENDED AMENDED 23a,27,28a-f,perME, g893 7/9	7/09 TT		
• exe	cian	pdical	X UNPENDED AMENDED 234,27,200 1,7		23d Da	ate of delivery
,60,	physician	≥	IF FEMALE.	regnancy	Mor	-
289	ding	2	23b. Was decedent pregnant in the past 12 months? 1	,		
Box 687	e attending p	leician/	1 Yes 2 No 9 Unknown		_	
m j	ne de y the hed f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			contribute to the cause of death?
P.O.	res that the d signed by the			1	Yes 2 No	o 3 Probably 4 V Unknown
S.	urres n sign	3 3				24b. Were autopsy findings available prior to completion of cause of
p.	v requir s been s	3			utopsy erformed?	death?
ပ် မ	he law	≀ ?			es 2 No	1 Yes 2 No
Division of Vital Records,	ysician: The l his certificate l	<u> </u>	26. Place of Death (C	Check only one)		
<u>:</u>	hysicia this cer	a la		Nursing Home 5		e 6 V Other: Scene
<u></u>	ng Phy After th	ē F	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ribe how injury	occurred
ם :	nding h.	in i	Natural 5 Pending Fd 6/30/09 Fd 9:19 am			- egger and the Meeting of the second
sio	Attend death ector:	in by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc	. 28f. Locat	ion (Street and	Number or Rural Route Number, City Laurel Valley C
. <u>≥</u>	after Dir	E 5	3 Suicide 6 A Could not be determined (Specify) residence	Abing	don, MI)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi			ce, and due to the	cause(s) and n	nanner as stated.
;	n 24 re Fu	letely	2 2a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	curred at the time,	date and place	, and due to the cause(s)
	To the Within To the	comp	alid Illamer stated.		29d. Da	te signed (Month, Day, Year)
		1	29b. Signature and title of certifier O.C.M.E.		July 1	, 2009
			Carde Hellan			
X	,		30. Name and address of person who completed cause of death (Item 23a) Carol Allan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
XU.	V		Oator Allari, III	21201		
		Sta	te 31. Date filed (Mod Pay Cery 2009 33 Registrar's Signature.			
	Rec	istr	ar			

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			FOR	State of Maryla				lental Hy	giene	0.0	01002
			State Registrar		Cei	rtificate of	Death		Reg. No. 🚄 🔱	09	21000
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JAMES C	. SEWA	RD			2. Date of Dea Month July	Day 2009	Year 9	3. Time of Death 12:00 p ^M
4.4	Examin		4a. Facility Name (If not institution, give sa				r Location of Death		4c. County		
1			3498 Old Annapolis			Laure		8. Date of Birt	Anne		del lace (State or Foreign
	Funeral Director		3/4-30-1140	7. Age (In y	rs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Da Apr. 28	y, Year)	Cour	ginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh fied a	io	MD Anne Aru	ndel La	aurel						1 □Yes 2 □ No XX
	or 28s)irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	try?
	th wil	ral	3498 Old Annapolis	Road		20724			U.S.A		
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show soiral Eveminer must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2XXMarried 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1	l .	Was Decedent of H If Yes, specify Cub 1 □Yes 2XXIo	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 14. Rac Blac Specify	k, White,	an Indian, etc. .ite
00-	2 hour	ted	15. Decedent's Educ	ation		dent's Usual Occup			16b. Kind of Bu	usiness/In	dustry
21215-0036	within jiene.	Completed	(Specify only highest grade Elementary/Secondary (0-12) Grade 9	College (1-4or 5+)	life.	kind of work done DO NOT use retire nanic	during most of work d)	ing	Car Ca	arrie	r
Maryland	s 1 and 2 should be filed of thealth and Mental Hygi item 27 is marked other other traumatic event, III	To Be (17. Father's Name (First, Middle, Last) Ray Calvin Seward				18. Mother's Name Nancy Sh		Maiden Surnam	ne)	
lar,	2 should I and Men is marke raumatic		19a. Informant's Name/Relationship (Typ	e. Print)			t and Number or Rur		er, City or Town,	State, Zip	Code)
≥,	and and lealth		Barbara Anne Seware				apolis Ro		rel, Mai		
ore			20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Re	amovai from State I		osition (Name of matory or other pla		Date	20c. Location -		
Baltimore,	it. Par rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)			ndel Crem		0/2009	Odento	n, Ma	ryland
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Euneral Service License	e / M007			es Funeral tt Avenue			land	20707
	Physician /Medical Examiner	L	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Acute Myoo Due to (or as a cons Coronary	cardial sequence of): Artery I	Infarcti		or respiratory a	rrest,		Approximate Interval Between Onset and Death
18.	ted	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence ory:						
8760, $\zeta_{\mathcal{S}}$	death certificate be executed e attending physician and d for use as the buriat-transit	lical Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
Ö	ertifica ing ph e as th		IF FEMALE:						-		
O. Box	the death certific by the attending p ached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnan☐ Other (spec <i>ify)</i> _	су		_	ite of deliv onth	ery Day Year
σ.	res that the de signed by the be detached		Part II. Other significant conditions con	tributing to death but not	resulting in the ι	ınderlying cause gi	ven in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
rds	quires n sigr ald be	d by		-				1 🗆	Yes 2⊠ X o	3∏ Pro	bably 4 ☐ Unknown
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed						24a. Was auto perfo	psy ormed?		opsy findings available impletion of cause of
ita	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dear				
of <	ys is	၉	1 ☐ Yes 2 ☐ X YX	ospital: 1 Inpatient 2		III 3 LI DOM			dence 6 □Otl	<u> </u>	fy)
sion c	ding J. After funer	Certification:	27. Manner of Death 1 ★ Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Yea		M 1]Yes 2□No		how injury occur		
Division	ital or Attencus after deathus after deathus al Director: lled in by the		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or To	wn, State)		al Route Number,
	the Hospital or a hin 24 hours after the Funeral Dire mpletely filled in L	edical	(Check only 2 Medical Examir one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, dea nination and/or i	nvestigation, in my	opinion, death occu	, and due to the rred at the time,	, date and place,	and due	to the cause(s)
	To the within 2 To the Comple	N	29b. Signature and title of certifier	Chapre	n		026339		July 6		
			30 Name and address of person who co	moleted cause of death	Item 23a) (Tyne	Print)					

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 7 2009

A.K. Chopra, M.D. 1421 S. Caton Avenue, Baltimore, Maryland 21227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Kimberly Renee Smith

2009 21584

		For State			Certific	cate of	Death				Re	g. No.			
Physiciar		. Decedent's Name (First, Middle	,Last)								Date of Deat Month	Day	Year	- 1	ime of Death
edical Examin		Kimberly D	Renee Sn	nith							luly 4, 200	9			1620 hrs
	4	la. Facility Name (if not institution 243 Fifth Street	, give street and n	umber)		41	c. City, Too Lothian		ocation of I			Ann	ounty of Dea ne Arund	el	
Funeral	5	5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last bi	irthday)	If Under	_	If Under		B. Date of Birt	h(MM/DD/	YYYY) 9. I	Birthpla eign	ce (State or Maryland
Director		213-31-9186	1M 2X_F		30	Yrs.	Months	Days	Hours	Min.	Dec.	L5, 1	978	Country	
any		Jsual Residence of Decedent 10a. State 10b. County		100	c. City, Tow	n or Location	on							100	I. Inside City Limits
			ard _		I	aurel									Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	0e. Street and Number					10f. Zip C	ode	0.050		1	0g. Citizen	of What C	ountry?	'
th the last		9518 Mellow C	lourt 12. Was De	and ant Eve	or in II S	13 W/26	Deceden	of Hisp	2072		ify Yes or No	- 14	USA Race - An	nerican	Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	ᅑᅵ	1 X Never Married 2 Ma	arried Armed I	Forces?		If Ye	es, specify	Cuban,	Mexican, F	Puerto Rio	can, etc.)		White, etc		ite
s after	⋧┞	3 Widowed 4 Dive	or Dates		ated) 16s	a. Decedent	Yes 2	•		nd of wor	k done		d of Busine		
2 hour "natu	ᆰ	Elementary/Secondary (0-12)		(1-4 or 5+)		during mo	st of work	ng life. I	DO NOT u	se retired	1)				
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natur or other traumatic event, the Medical Exe	ompleted	12th		Ø		Rece	ption						eterir	nary	
5-0 led wi Hygie other	5	17. Father's Name (First, Middle,	Last)					18	8.Mother's	Name (F	irst, Middle,	Maiden Su	rname)		
121 d be fi ental arked	B	John Timothy	Smith		- 17	10h Mailina	Addroso	(Chront	Vic)		Moore ral Route Nur	nher City	or Town S	tate Zir	Code)
D 2 should and M 7 is m	₽	19a. Informant's Name/Relations Vickie Smith/N				9518					Laurel		2072		
and 2 sho lealth and tem 27 is traumati		20a. Method of Disposition				e of Disposi	tion (Name				Date		cation - City	or Tov	vn, State
MOFE Pages 1 nent of H ant: If i		1 X Burial 2 Cremation		from State		natory or oth Linc		em.	Ι.	7/9/2	2009	Br	rentwo	ood,	MD
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other transmatic event, the Med	+	4 Donation 5 Other Sp 21 Signature of Funeral Service			1 101							Fun∈	eral H	Iome	P.A.
Balt permit. Depart Import injury	\$	- much	7300k		M0110						, Lau			207	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	on each/line.							rdiac or r	espiratory ar	rest, shock	k, or heart		Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease	a. Narco			n) in	toxic	ati	on					-	Death
	1	or condition resulting in death)	Due to (or as	a consequ	uence of):										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	uence of):										
nted AM	ΕÜ	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):									\top	
		X UNPENDED	d	23a,	P11,2	./,28a	-1,pe	rmE	, g89	4 8/	3/09	rr		\top	
ficate be g physicia s the buria	ğ-	IF FEMALE:	23c. If ye	s, outcome	of pregnan	icy		_				23d.	Date of del	ivery	
687 ertific ding p e as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Dec		ne of death	2 Fe			Ectopic	pregnan	су	N	/lonth	Day	Year
ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certific reach. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as the	/sic	1 Yes 2 No 9 V Un		gnant at tin	ne or death	5 Ot	her (Spec	ify)							
D. B t the d by the		Part II. Other significant condit		to death b	ut not resul	Iting in the u	underlying	cause g	iven in Pa	rt I.					e cause of death?
P.(Completed by	Cocaine use									1 Y	es 2 🗸	No 3	Probab	ly 4 Unknown
cords aw requi	lete										24a. Was	psy	prio	r to con	osy findings available apletion of cause of
Reco The law icate has	d Mo					•						ormed? 2 No	dea 1 ✔	th? Yes	2 No
tal Reitian: The certificate	Be C	25. Was case referred to medica							of Death ((Check or	nly one)				
Vits hysicis	o١	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient		R/Outpatient		JA	Other ₄		Home 5		ce 6 🗸	Other: S	Scene
n of Vital I ling Physician: After this certifi funeral director,	Ë	27. Manner of Death 1 Natural 5 People		ite of Injury inth, Day,Yea	r) 28	Bb. Time of	Injury 2	-	ry at Work res 2	1	28d. Describe unk	now injur	y occurred		
Sior Attend death. ctor:	ξį	Pen	stigation ra	7/4/0	9 F	d 4:0	_			,,,		(Street an	id Number (or Rural	Route Number, City
	Certification:	3 Suicide 6 X Cou	id not be rmined (Speci	1	ry - At nome nouse	e, farm, stre	et, ractory	onice b	ullaing, et	c. 1	or Town, Lothia	State)24	3 Fil)	th	St.
Hospi 24 hou Funer tely fil		4 Homicide 29a. Certifier 1 Certifying P	hysician: To the I	nest of my l	knowledge,	death occu	rred at the	time, da	ate and pla	ace, and c	due to the ca	use(s) and	manner as	stated	·
To the Hos within 24 h	Medical	one) 2 Medical Exa	and manne	is of exami r stated.	nation and/	or investiga				curred at	une ume, dat				n, Day, Year)
	Σ	29b. Signature and title of certifi	er				290	O.C.I	e number				5, 2009	(WIOTH)	, Day, reary
		Maryonie 1	hellow	U.	-U- (P) - \		0.0.1	· ¥ I · ► ·			July			
ϕ		30. Name and address of person Margarita Korell MD.	n who completed c Assistant M				enn Str	eet, B	altimore	e, MD 2	1201				
	ate	31. Date filed (Month), Day Year				ake									
5 1		LIH HI / ZUMM	(Bue serve	L 4	. 136	TUCA									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 6:10 P M July 2009 Siatkowski Joseph Daniel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 8358 Bletzer Road 8. Date of Birth (Month, Day, Year)
Sept. 25,1926 If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**X** M 2 □ F Yrs. 82 Maryland **Director** 219-20-5773 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show Dunda1k 1 ☐ Yes 2K No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 8358 Bletzer Road death v Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. δ 3 ₩ Widowed 4 □ Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If them 27 is marked other that any injury or other traumatic event. If 12 Years Assembly Line Worker General Motors, Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karolina Pucowna Adam Siatkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Friend) 8358 Bletzer Road Dundalk, Maryland Janet Lorenz Baltimore, 20b. Place of Disposition (Name of Cometery Crematory or other place HOLY Cross Polish Date 20c. Location - City or Town, State 20a. Method of Disposition Harial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/6/2009 | Baltimore, Maryland National Cemetery 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 20 y13 **Physician** Due to (or as a onsequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed and burial-trai Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Por in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Cancer 2 No 3 Probably 4 Unknown 1 Yes Completed Hypertensive Atheroscleratic Courcha vasculur Discore 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □Yes 2 LANo certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this completely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in experimental date.

Division of Vital Hospital or Attending e Funeral I within 2

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Rout Ed. Paltimere MD 21219 Parent Dourt - 75cc

31. Date filed (Month, Day, Year) 32. Registrar's Signature.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

July 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Smith Eugene 0 Preston /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner tranklin Savare CAHIMA 8. Date of Birth (Month, Day, Year)
July 27,1929 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min 232-32-6774 1 1 M M 2 □ F 79 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedichl Examination was be notified at Middle River 1 ☐ Yes 2 No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21220 406 Machias Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Almied Foldes:
1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1946–48 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 5 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilda K. Pritt ပ Charles E. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1001 Nottingham Road Elkton, Maryland Mrs. Robin L. Skeen (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. July 1, 2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 mer art 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has b I director, page 2 sh autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐∦es 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Marner of Death 28b. Time of 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident illed in by the f 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

31. Date filed (Month, -Day: Year) State Registrar

30. Name and address

29b. Signature and title of certifier

Franklin

pers, n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

90

29c. License numbe

Square Dr. Baltimore, MD 21237

Funeral Director 28a-f show

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** WILLIAM SHULMAN 0355 7009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Balti more N/A Sinai Mospital ot If Under 1 Year | If Under 24 Hrs. 5. Social Se**28** ty Number 212 - 94 - 943 **6** 8. Date of Birth (Month, Day Year) 02/27/1931 Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) Days Hours Months 78 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evernine must be notified at once. Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6636 CHIPPEWA DRIVE 21209 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No Specify. ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHEMICAL ENGINEER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS KASACHKOFF SHULMAN SARAH ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGERITE SHULMAN / WIFE 6636 CHIPPEWA DRIVE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CHEVRA AHAVAS CHESED | 07/05/2009 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Melt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (o as a consequence of): **Examiner** neumania Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Bacteremia burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a d be detached fo 5 ☐ Other (specify) 9 Unknown 9 Unknown The law requires that Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, carcinomo 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Panatorenia 25. Was case referred medial examiner? 1 ☐ Yes 2 ▼No Hosp perform this certificate 1 ☐ Yes e Hospital or Attending Physician: 124 hours after death.

e Funeral Director: After this certificalletely filled in by the funeral director, p Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN KUBIN, MD, SINAI HOSPITAL OF BALTIMORE, Z401 W. BELVEDGRE, BALTIMORI, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denve S. parls

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 8893 7-7-09 yt. State of Maryland Bepartment of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 4 2009 8:42 Stoffel William Roger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F Maryland 215-40-4267 9. 1941 Director Aug. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it e Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21244 2007 Kennicott Rd. Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Honeywell Corp. Mechanical Drafting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hoeriks Ida Mae Stoffe1 William Joseph ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2007 Kennocott Rd., Baltimore, MD 21244 Carol H. Stoffel (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cemetery 17/9/09 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Approximate
Interval Between
Onset and Death
Manual Comments
Oncomments
Oncom 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the criping Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) the death certificate be executed the burial-transit Exami and Due to (or as a consequence of): signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying çause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: ours after death.

neral Director: After this certifical in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2**⊟**1√0 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1-Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifie N. Charles St.

State Registrar

32, Registrar's Signature 31. Date filed (Month, Day, Year)

completed cause of death Item 23a) (Type, Print) Sin(

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		For State Registrar	State of Marylan	id / Departme <i>Certifica</i>			Mental Hy	/giene Reg. No.	C 1. 1.	01500
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Funeral Director		· · · · · · · · · · · · · · · · · · ·	M 2x F	Yrs Month		Hours Min.	(Month, E	ay, Year) -17–19	928	vA
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within 72 hou mithin 72 hou me. Ithan "natura e Medical E	Completed	15. Decedent's Ec (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's L (Give kind of life. DO NO Disak	work done Tuse retired	during most of wor	rking	16b. K	of Business	,
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permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	emos			ess of Facility North Ave	March nue Ba)2
Physician /Medical Examiner		23a. Part 1. Enter the disease, or only shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line. a							Approximate Interval 8etween Onset and Death
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leath certificate be executed attending physician and of for use as the bunal-transit	=	resulting in death) Last	Due to (or as a conseq	juence of):						
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l or Attending Physical din by the funeral d	ation:	27. Manner of Death 1 M Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Inju Wor 1 _	ry at rk? Yes 2	28d. Describe	e how injui	y occurred	
그 호흡하는	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify	y) 			Cify or To	wn, State		ural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	Medical		vsiclan: To the best of my kno niner: On the basis of examina and manner stated.							
To the complete th	ž	29b. Signature and title of certifier	Dr. Kwan		29c. Licens	re number 42-ØØ1	Ø779		te signed (Monti	
		30. Name and address of person who		m 23a) (Type, Print)	-					ore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year)	32. degistrar's Signa	A back	1					

Baltimore, Maryland 21215-0036

	/M	ledi ami
- April 1	Exa	ımi
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director.

		Please	Type or Prin							egible.	
		For State	State of Ma	aryland /		rtment of F tificate of I	lealth and I	-	-	1000	21500
		State Registrar 1. Decedent's Name (First, Middle, La	st)		Cer	tilicate of i	Deam	2. Date of De	Reg. No.	100	3. Time of Death
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/Medic Examin		4a. Facility Name (If not institution, given	e street and number)			4b. City, Town, or	r Location of Death	1		ounty of Dea	
		Gilchrist Hospic				Towso				Baltin	
Funeral		5. Social Security Number 6. S	Sex 7.Ag I⊠M 2□F	je (In yrs. last t	oirthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	C	rthplace (State or Foreign ountry)
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or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending physin by the funeral director, page 2 should be detached for use as the	Physician/Medica	1 ☐Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 ∐	Other (specify) _		·			,
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slcian certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	ath (Check only o			(
Physer this eral di	:. To	1 ☐ Yes 2 No 27. Manner of Death	1 ∐ Inpati	ent 2 ER/0	. Time of	t 3 DOA 28c. Injur	4 ☐ Nursing F	lome 5 Resi 28d. Describe		Other (Sp occurred	ecify) NOSple
ath. r: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	n (Month, Da	ıy, Year)	Injury		k? Yes 2 □No				
r Atte	Certification:	3 Suicide 6 Could not be determined	20e. Place of In	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (City or To		Number or F	Rural Route Number,
oital o urs aft eral Di		One Compliant		-611							
To the Hospital or Attending Phystcian: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	of examination	ige, death and/or inv	estigation, in my o	me, date and place opinion, death occu	e, and due to the arred at the time,	date and	and manner a place, and du	as stated. ue to the cause(s)
To th within To th comp	Me	29b. Signaturand title of certifier				29c. Licens	e number		29d. Date	signed (Mor	nth, Day, Year)
1,1,		Mean	w)			US 8	5505		701-	7 6	2009
41		30. Name and address of person who	HARLES	W	a) (Type, F	Print)	3303 Curl	5 50	Ta	NOW	M
Sta Registra	te ar	31. Date filed (Month, Day, Year) 20	09 Registr	ar's Signature	ba	wed .					

State of Maryland / Department of Health and Mental Hygiene

						,	C	ertifica	te of l	Death		Reg. No.		Trois I	· ·
31			1. Decedent's Name (Firs	st, Middle, La	st)						2. Date of Do Month	eath Day	Year	3. Time	of Death
u	Physici /Medio		Rose		Lor	raine		Tr	uitt		July	2, 200		9:	40AM
8	Examir		4a Facility Name (If not in						1		or Locetion of Dea				
			Crofton Conv	valesc	ent Cen					Crofton		Anne			
3	Funeral Director		5. Social Security Numbe 217–30–3758	1	ex □M 2ĂF	7. Age (In yrs. 98		Months	er 1 Year Days	If Under 24 H Hours M	lin. (Month, D	th ay, Year) 10,1911	9. Birthp	olace (Statentry) MD	te or Foreign
	and		Usual Residence of Dece 10a. State 10b.	County		10c. Ci	ty, Town o	r Location					1	IOd. Inside	City Limits
	Manyl-	0	MD Ann	ne Aru	nde1	G1	en B	ırnie						1 □ Y	es 2 No
	the notifie	Funeral Director	10e. Street and Number					10f. Z	ip Code			10g. Citizen of V	Vhat Cour	ntry?	
	3a o	Ē	105 4th Aver	nue SE				21	061			U.S.A	<i>4</i> .		
	deat frame	ner	11. Marital Status		12. Was Dec	edent Ever in U	I,S.	I3. Was Dac	edent of H	lispanic Origin?	(Specify Yes or Nuerto Rican, etc.)	o- 14. Rac	e - Americ	can Indian, etc.	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, the Marical Examiner must be notified at once.	by	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □		1 ☐ Yes If Yes, Gi Year or D	2X No				Specify:			whi	.te	
5-0	72 hc natur	eted	15. E (Specify on	Decedent's Ed	ducation de completed)		16a. De	ecedent's Us live kind of w	ual Occup vork done	ation during most of s d)	working	16b. Kind of Bu	ısiness/In	dustry	
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מ	iled v Hygie ther t	ပိ	17. Father's Name (First,	Middle, Last.			Keg.	lsterr	ea Ni		Name (First, Middl	Health e, Maiden Surnam		<u> </u>	
au	d be f antal I	Be c	Benjaman Ch							Lu1a					
<u>Z</u>	shoul nd Me mark matik	ပို	19a. Informant's Name/F		Type, Print)		19b. N	lailing Addre	ss (Street		Rural Route Num	ber, City or Town,	State, Zij	o Code)	
Σ	nd 2 g lith ar 27 is r treu		Mr. Howard	C. Tru	itt Jr	./Son	10	5 4th	Aven	ue SE G	len Burn	ie, MD 2	1061		
Ē,	of Hear		20a. Method of Disposition				Place of D	isposition (N crematory or	ame of	ce)	July 7,	20c. Location -	City or To	own, State	•
Ë	Page nent c nrt: If					State	-	idge 1			2009	Elkridg	e, M	D	
att	permit. Departmimporta		21. Signature of Funeral	Service Licer	nsee						ingleton				
œ	89588		I US	ノミベ	1	Mou		Servi	ces P	A 1 2nd	Ave. SW	Glen Bu	rnie	, MD	21061
	Physician		23a. Part1. Enter the dis shock, or heart failu	ease, or com ure. List only	plications that one cause on	caused the dea		enter the m	ode of dyir	ng, such as card	diac or respiratory	arrest,			mate Between nd Death
	wedical?		Immediate Cause (Final disease or condition		B	reum	000	ia					1	WH	eeks
	Examiner	L	resulting in death)		a	New to (or as a coi	nsequence o	of):	0 1			1		
_	ed sit	nine.			b. CLM					Pulm	onony	Disea	x	75	ous
5	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Examiner	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury	ns, iate		,		nsequence o	,	4	,		1		
9	siciar b buria		Cause. Enter Underlying Cause (Disease or injury that initiated events	~	c. Ca	Due to (D M	10 p	at	ny				Je	ans
68760,	ificate g phy as the	edicai	resulting in death) Last		A	Due to (c lea	isequence of	··					10	0100
Box	anding use	M			d. /47/	MOS	CITON	0 5 12	>					7-60	ans.
œ.	death	sicia	Part II. Other significant	conditions	ontributing to d	leath but not re	sulting in th	ne underlying	g cause giv	ven in Part I.	23b. Di	d tobacco use co	ntribute	to the cau	se of death?
P.O.	at the	Physician/									1[yes 2XNo	3 🗆 Pro	obably 4	4 🗌 Unknown
<u>ග</u>	The law requires that the death ate has been signed by the atler page 2 should be detached for r	b											7.4h V	Voro autor	osy findings
Vital Records,	w require been sig	Completed by										is an autopsy formed?	a	vailable prompletion	ior to
Şeç	e law has b ge 2 si	npie										_		f death?	
<u>=</u>	: The cate				1							Yes 2 No	1	□Yes	2 LI No
\frac{1}{5}	Physicien: r this certific aral director,	Be c	25. Was case referred to examiner?	medical	Hospital:		7.50/0-4-	-4:4 2 -	Oth Oth	hor: 4	Death (Check onlying Home 5 Re		ner /Sner	ify)	
	Phys r this aral di	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death		28a. Date	of Injury	ER/Outp 28b. Tin	ne of	28c. Inju Wo	4 DU IVUISII		e how injury occu		"7/	
on	Attending or death. ector: After by the fune	tior	1 Natural 5 □ 2 □ Accident	Pending investigatio		nth, Day Year)	Inju	M M		rk?]Yes 2□No					
Division of	To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:		Could not be determined	289. Plac	e of Injury - At I ling, etc. (Spec		, street, fact	ory, office		28f. Location City or 7	(Street and Num. own, State)	ber or Ru	ral Route I	Number,
	pital ours a seral Derail	S	29a. Certifier 1🗙	Cortifuing Ph	weiclen: To the	e hest of my kn	owledge o	leath occurre	ad at the ti	me date and p	lace, and due to th	e cause(s) and m	anner as	stated.	
	To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only 2	Medical Exa	miner: On the b	pasis of examin nner stated.	ation and/	or investigati	on, in my	opinion, death o	occurred at the tim	e, date and place,	and due	to the cau	ise(s)
	Fo the	Me	29b. Signature and title of	of certifier	1			2		se number	~	29d. Date signe		, Day, Yea	ar)
			Kal	Kesk	h as	Wa	M	D	D	201	08	7/2	109		
	\		30. Name and address of	f person who	completed cau	use of death (Ite	m 23a) (T	/pe, Print)							
_	\		Dr. Arona		Gallant	Fox La	ane B	owie,	Mar	yland 2	0715				
	Sta Regist		31, Date filed (Month, Da	7 2009	aner	Registrar's Sign	nature	Plan							

State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 200^{yg ar} Catherine Pitts Thaver 21:01PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 401 Verona Court Millersville Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 30, 1927 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ KF 82 217-26-6422 MD **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madical Exprinkt must be notified at once. Director 1 □Yes 2 □ No MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Verona Court 21108 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ş Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel County Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Pitts Anna Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathy T. Lloyd/Daughter 401 Verona Court Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 8 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW GLen Burnie, MD 21061 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2006 Remente /Medical Due to (or as a consequence of): Examiner Lene (on Sequentially list conditions, if any, and in the Linderlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year P.O. I 5 ☐ Other (specify) ☐Yes 2. No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1-16 Natural 2 Accident 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00038912 Grisn Lune 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 7845 Oakwoos tod 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

				For State Registrar	State of I	Marylar		artment of <i>tificate o</i>			ental Hy	/giene	2009	2159	3
				Decedent's Name (First, Middle,	Last)	***					2. Date of De	eath		3. Time of Dea	ıth
.0		Physici		Raymond Marvin	Геаbo						Month	Day 28	2009	8.471	M
N)		/Medic		4a. Facility Name (If not institution,	give street and number	er)		4b. City, Town	n, or Location	of Death	06	1	County of Dea	9	-
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N		Funeral				Age (In yrs.	last birthday)	If Under 1 Ye			B. Date of Bi		9. Bir	thplace (State or For	reign
34		Funeral Director		214-34-3203	1⊠M 2□F	72	Yrs.	Months Day	ys Hours	Min.	Month, D. Nov 17	ay, Year) 1 19		yland	
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214	vlano	at at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Li	mits
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	the	r 28a noti	irec	10e. Street and Number				10f. Zip Code	e			10g. Citiz	zen of What Co	ountry?	
	wit	3a o st be	Funeral Director	1801 Wentworth	Road			2123	4			USA			
	death	ms 2	Jer	11. Marital Status	12. Was Decede		l.S. 13. V	Was Decedent of f Yes, specify C	of Hispanic O	ngin? (Spec	ify Yes or N	0-	14. Race - Ame		
30	ter o	or ite		1 Never Married 2 Marrie	Armed Force						ican, etc.)		Black, Whi	te, etc. White	
A	nis a	ar", c	þ	3 ☐ Widowed 4 € Divorced	If Yes, Give Year or Date	s:		I∐Yes 2⊠N	No Specify	y:			Specify:	WIIICE	
EABO	:1215-0036 within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show edical Examiner must be notified at	Completed	15. Decedent's	s Education		16a. Deced	lent's Usual Oc	cupation U1	nk	~	16b. Kir	nd of Business	/Industry unk	
1	il i	an "r Med	ed d	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. L	OO NOT use ret	tired)	or working	ð				
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# -	ב ב	al H)	Be (17. Father's Name (First, Middle, L							First, Middle		,		
6	<u>a</u>	Ment Irked Itic e	2	John Edward Tea	bo				Bet	ty Ama	ında Ja	ackso	n		
RAYMOND	altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours af	Department of Health and Mental Hygiene. Important, If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical J once.		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	ig Address (Stre	eet and Numi	ber or Rural	Route Numi	ber, City o	r Town, State,	Zip Code)	
> 1	and .	n 27		Joan Teabo/sist	er					ake Ci	rcle l	Naple	s, Flo	rida 34119	}
X	es t	r of Te		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Filamoural from Sta		Place of Disport Cernetery, cren	sition (Name of natory or other)	place)	Da	ite	20c. Lo	cation - City or	r Town, State	
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	<u> </u>	partn ports y Inju		21. Signature of Funeral Service L	icens		22	. Name and Ad	dress of Faci	ility	(55 11	D 1			
1	n 8	E E E		Elmil'	de, Dir	ector	Ba	ate Ana ltimore	atomy I	Board yland	2120¥	. Bal	timore	Street	
		101		23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that cause	sed the deat								Approximate Interval Between	n
	PI	hysician		Immediate Cause (Final	-		Owner	C.	1000	1000				Onset and Deat	:h
		/Medical		disease or condition resulting in death)		as a consec		EL OF	BSTRI	CII	310			-	
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		£1 [Jer	Sequentially list conditions,	Due to (or	as a consec		d. Art. and					- 8	i	
	X/50, cate be executed	physician and as the burial-transit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· c	A	SPERA	TION	PHE	MONE	A				
	exec	an an rial-tr	Ě	resulting in death) Last	Due to (or	as a consec	quence of):								
í	8/60, cate be ex	ysicia ne bu	dical	li .	d										
		g ph as th	led		1										
	Box	attending p for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me pf pregn	ancy	Cotonio areana				2	23d. Date of de	elivery	
	deat a	d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan	t at time of o	death 5□]Ectopic pregna] Other <i>(specify</i>)				Month	Day Year	r
9	I RECORDS, P.O. BOX 6 The law requires that the death certific	been signed by the should be detached	Completed by Physician/Me	9 Unknown	9□Unknowi	n									
	stha	ned e det	γP	Part II. Other significant condition	ns contributing to deat	h but not res	sulting in the ur	nderlying cause	given in Part	t I.	23e. Did	tobacco u	se contribute t	to the cause of death	1?
-		n sig uld b	b b	DIABETES	MELLITI	25					1 🗆]Yes 2[□No 3□F	robably 4 Unkr	nown
	O 2 ≥	shee	lete	LIUDEDTE	USCON						24a. Wa	s an	24b. Were a	autopsy findings avai	ilable
	Pe Pe	ate has	ᇤ		0 51 0 0	-					auto per	opsy formed? 2. No	prior to death?		e of
3		certificate ector, pag	ŭ	25. Was case referred to medical					OF Disc	oo of Dooth	1□ Yes (Check only	_	1 □ Ye	s 2 No	
5	Sicia	is certific director,	Be c	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2	1ER/Outpatien	t 3 DOA	Othor:				6 □Other (Sp		
	<u>o</u> Ę	h. After this funeral dir	- T	27. Manner of Death	28a. Date of I	njury	28b. Time of	C OLL DOX	njury at Nork?		Bd. Describe			өспу)	
		h. fune	tior	1 ☐ Natural 5 ☐ Pending investigation		Day Year)	Injury		<i>N</i> orƙ? I∐Yes 2[□No					
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č	DIVISION OF VITAL RECORDS, P. I or Attending Physician: The law requires that	after Dire J in b	Certification:	4 ☐ Homicide determin	building,	, etc. (Speci.	fy)				City or To	own, State)		
	spita	neral rille		29a. Certifier ↑ Certifying	Physician: To the be	est of my kno	owledge, death	n occurred at the	e time, date a	and place, a	nd due to the	e cause(s)	and manner a	as stated.	
	e 79	e Fu	Medical	(Check only 2 Medical E	xaminer: On the basi and manner	s of examina stated.	ation and/or in	vestigation, in n	ny opinion, de	eath occurre	d at the time	e, date and	d place, and du	ue to the cause(s)	
	o ţ	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	A -4=			29c. Lice	ense number	r		29d. Dat	te signed (Mor	nth, Day, Year)	
	, ,	0		Satist	Kabon MD			D	ESC	100		. 7	NE	28 2005	7
				30. Name and address of person v		of death (Iter	m 23a) (Tvne		1=2 (1996	X 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	۷
				SATISH KAR		5601		H RAVI	EN	BU	JD	BAI	TEMOR	EMDZ	1229
	7.	Sta	ite	31. Date filed (Month, Day, Year)		istrar's Sign		- 1 4 - 1 4					, = 11 (0)	1110	
		Registr		JUL () 7 201	14 /6-12	. 19	160.4	Park							

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July_ 2009 10:30p Trego Janet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bright View Assisted Living Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
April 25, 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F 89 Maryland 1920 Director 213-01-6168 Usual Residence of Decedent 10d Inside City Limits 3a or 28a-f show 10c. City, Town or Location 1 ☐ Yes 2 ▼ No Director Maryland Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 331 Clyde Avenue 23a 21227 USA traumatic event, the Medical Exeminer must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed vent of Health and Mental Hygient; If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry J. Selby 5 Schach ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any injury or other trau <u>once.</u> Thomas I. Trego, Jr. (Son) 331 Clyde Ave., Lansdowne, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory
@ Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/10/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nd Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent, of): Examiner rinosis Sequentially list conditions, if any, leading to himse list cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical aftending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 💢 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performed? this certificate I or Attending Physician: after death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled ir the Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signafule and title of certifier 29c. License number 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) Street Sinte 200 Renteration 23 Main

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Registrar's Signature

09-05199 John Willford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

n Willford		I- For State	Stat	e of Maryla	and / Depar	tment of ificate of	Health as Death	nd Menta	al Hygi	ene Reg	. No.	0.0	9 215	59
Physici	1	Registrar 1. Decedent's Name (Firs	st, Middle,	Last)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Date of Death		1	me of Death 530 hrs	1
er' Exami	ω. · · ·	John		Willif	ord					Month Uly 2, 2009	4c. County of I		330 1115	-
		4a. Facility Name (if not i		give street and no	umber)	4	b. City, Town, Severn	or Location of	Death		Anne Arur			1
		809 Danza Road			7. Age (In yrs. la	et hirthday)	If Under 1 Ye	ear If Under	24Hrs. 8	. Date of Birth	(MM/DD/YYYY)	9. Birthplac	e (State or Foreign	1
Funeral		5. Social Security Number 218-36-947		. Sex	7. Age (III yis. la		Months Da	ays Hours	Min		1, 1941	Country) Mary)	1
Director				1 X M 2 F	07	Yrs				11011 2	2, 2012			ゴ
any		Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Locati	on					1	. Inside City Limits Yes 2 X No	
		Maryland	Anne	Arunde1	Se-	vern							**	4
urylan Sa-fsl atono	Director	10e. Street and Number					10f. Zip Code	e		10	g. Citizen of Wha	t Country?		
vith the Maryland s 23a or 28a-f show a notified at once.	ä	809 Danza	Road	1				1144			United	State	S Indian, Black,	4
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "naturalt", or items 23a or 28a-f she arise event, the Medical Examiner must be notified at once	rai	11. Marital Status		A-mod I	ecedent Ever in U.	S. 13. Wa	s Decedent of es, specify Cul	Hispanic Origi ban, Mexican,	in? (Spec Puerto Ri	ify Yes or N o- can, etc.)	White,		indian, black,	1
death or iter	Funeral	1 Never Married		1 Yes	2 X No	1	Yes 2X				Specify:	Whit	. 0	
after ral", c	۾	3 Widowed 4		rced If Yes, Give Your Dates:		16a Deceder	nt's Usual Occu	pation (Give I	kind of wo	k done	16b. Kind of Bus			1
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36 ain 72 iin 72 iin 74 dical	be	6 yrs.	19 (0-12)		,	Ma	intena					oi Ma	ryland	4
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Completed by	17. Father's Name (Firs	t, Middle,	Last)				18.Mother	's Name (i	First, Middle, N	Maiden Surname)			
215 be file stal H ked o	Be	Troy Th		Willif	ord, Sr.			Agı	nes_	Betty Boute Num	Russ nber, City or Towr	. State, Zir	o Code)	-
21 lould I d Mer is man	ြို	19a. Informant's Name/									e, Maryl			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In the man an arrived other than "natural", in yor on other resumatic yeart, the Medical Examiner.		Mrs. Ruby	Russ	ell / Si	ster 120b.	Place of Dispo	Severn sition (Name o	f cemetery,	CIOW	Date	20c. Location -	City or Tov	wn, State	1
ore, s l ar of Her If ite		1 X Burial 2	Cremation	3 Removal	from State	crematory or o	ther place)		7.0	(2000	C1 Pr	. 1 0	MD	
Page Page ment c		4 Donation 5	Other Sp	ecify:	G1	en Have	en Mem.	Park tress of Facilit	1/9/	2009	Glen Bu Funeral			\neg
Baltimore, permit. Pages I at Department of Her Important: If ite		21. Signature of Funera	al Service	Ercensee	Z MO11	21 5	rvices	1 2n	d Ave	SW G1	en Burni	ie, MI	21061	
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hysicia ledica		failure. List only of	one cause	on each line.	tensive	athero	sclerot	ic car	diov	ascu1a	diseas	e	Death	_
kamine	r	Immediate Cause (Fina or condition resulting it	ai disease n death)	Due to (or a	s a consequence	of):		_						
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Boy death	od for	1 Yes 2 No			nknown			auso siyon in l	Dort I	23e. Did	tobacco use conf	ribute to th	e cause of death?	\dashv
P.O. s that the gned by t	etache		ant condi	tions contributir	ng to death but no	t resulting in th	e underlying ca	ause giver iii i	raiti.				bly 4 🗸 Unknow	
ial Records, P.O. B sian: The law requires that the d certificate has been signed by the	d be d	n ———								24a. Wa	s an 24b.	Were auto	psy findings availa	ible
of Vital Records, ng Physician: The law requir ther this certificate has been s	pinous									per	opsy formed?	death?	mpletion of cause of	or
ecc he lav ate ha	age 2	E								1 ✔ Yes	2 No	1 V Yes	2 No	-
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of ing Pl	2.7	27. Manner of Death		(1)	Date of Injury Jonth, Day,Year)	28b. Time		1 Yes 2						
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Division lal or Attendirs after death.	led in by	1 X Natural 2 Accident 3 Suicide 4 Homicide		uld not be 28e. ermined (Spe		it nome, lam, s	street, ractory, t	511100 2 01101119	,	or Town	, State)			
Division of Vital To the Ligaritation attending Physician: within 24 hours after death.						ledge death o	courred at the f	ime, date and	place, an	d due to the ca	ause(s) and mann	ner as state	ed.	
DK = 5	completely	(Check only 1 one)	ertifying Jedical Ex	caminer: On the b	asis of examinatio	n and/or inves	tigation, in my	opinion, death	occurred	at the time, da	nto diria piaco,			
Within 2	com	(Check only one) 2 V N 29b. Signature and ti		allu Illali	ner stated.			License numb			29d. Date si	gned (Mon	nth, Day, Year)	
		1	K	15 Vu.	11.11.	111		O.C.M.E.			July 4, 20)09		
7		30. Name and addre	MILL.	on who completed	cause of death (tem 23a)								
P		Pamela E. S			ant Medical E	xaminer	111 Penn	Street, Bal	ltimore,	MD 21201				
	Sta	31. Date filed (Month	n, Day, Yea	r) 3	32. Registrar's Sig									
			7 200	17.	and the	book	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 18, 2009 6:00 A Karen Williams /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges St. Thomas More Nursing & Rehab Hyattsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day | Min. | Dec 7, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 □ M 2 🖾 F 53 Washington DC 578-76-0386 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examirer must be notified at MD Prince Georges Hyattsville 1 ☐ Yes 2K No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or amy Injury or other traumatic event, the Medical Examiner must be nonce. 20782 4922 LaSalle Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2½ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married black 1 ☐ Yes 2 No Specify. Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation U11 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) federal government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Mary Ariel Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrew Williams/son 4331 Telfair Blvd. Apt El05 Camp Springs, MD 20746 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street ervice Lice a S Director Baltimore, Maryland 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) torit Rioscleratic CARDIOVASCULAR WISEOSE Physician 4-Darn /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Wellitzes Schizopheenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? phenal Vascular Disease 24a. Was an autopsy perform ituman Immunodeficiency virus 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Paul A. DEVORE MOYZOS QUEENSBURY RA MYCITTS VILLE MIS 20181 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

01852

29d. Date signed (Month, Day, Year)

	4	For State Registrar	State of Marylar		artment of H rtificate of L		/lental Hy	giene Reg. No. 2	1119	21597
Physicia		1. Decedent's Name (First, Middle, Las					2. Date of De Month June	Same to	Year 09	3. Time of Death 12:01 ^{P M}
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	-	Beth			4c. Count	y of Death	ry
Funeral Director		310-20 3733	ex		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 1 2 / 0 9	/1926	9. Birthp	place (State or Foreign htry) IN
the Maryland r 28a-f show		Usual Residence of Decedent 10a. State 10b. County MD Monto	gomery 10c. C	ity, Town or Lo					1	0d. Inside City Limits 1X Yes 2 □ No
with the	Funeral Director	10e. Street and Number 10714 Potomac	Tennis Lar	ne	10f. Zip Code 208	854		10g. Citizen of	What Cour	ntry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. the Whysian the than "natural", or items 23a or 28a-f show ant, the midical Event that it is midical Event that it is midical Event that it is midical.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ∏Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 █ਿ*No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bl	ace - Americ ack, White, ify: Wh	etc.
within 72 hours ene. than "natural"	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired Homemake	luring most of work)	king	16b. Kind of I	Business/In	
permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, In Medica.	To Be Co	17. Father's Name (First, Middle, Last) Harry Albert	Colvin			18. Mother's Nam Julia			me))rr	
and 2 shou ealth and N 27 is mar er traumat		19a. Informant's Name/Relationship (Amy Mars / Day	ighter	137		rthy Ro	ad, Ge	rmanto	wn,	MD 20874
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Departition Depart		21. Signature of Funeral Service Licer	1 Mousto	W I		Cremat 413, Ba	ltimo	ce, MD	5 2120	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Respirat Due to (or as a conse	tory	Failure	ig, such as cardiad	or respiratory	arrest,	2	Approximate Interval Between Onset and Death $4-72nrs$.
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Attending Physician: The law requires that the death certific robath. robath. sctor: After this certificate has been signed by the attending p. sctor: After this certificate has been signed by the attending p. y the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[⊒ Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			Date of deliv	rery Day Year
signed by	5	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.				the cause of death?
The law require sate has been si page 2 should b	Completed						24a. Wa aut per 1 □ Yes	opsy formed?	o. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 □ No
sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt 3 🗆 DOA Oth	26. Place of Dea	th (Check only	one)		
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Hospital 24 hours Funeral stely filled	edical Ce		nysician: To the best of my kr niner: On the basis of examin and manner stated.							
To the within 2 To the comple	Me	29b. Signature and title of certifier	ZZ		29c, Licens	e number 6 8 6 6 0		29d. Date sig		

State Registrar 31. Date filed (Month, Day, Year) 0 7 2009

32 Registrar's Signature pare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June 25. 2009 5:56 A M **Physician** Venus Chris Yeatras /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Johns Hopkins Bayview Hospital 9. Birthplace (State or Foreign Ohio) 8. Date of Birth (Month, Day You If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖫 F 84 286-20-5197 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Madical Evantmer must be rutified at any Injury or other traumatic event, the Madical Evantmer must be rutified at any Injury or other traumatic event. 1 Yes 2 No Winchester Funeral Director Virginia N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22601 527 Virginia Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angeline Varlas Nicholas Schoolev ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 527 Virginia Avenue Winchester Virginia 22601 Chris S. Yeatras/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/09 Winchester Virginia Mount Hebron Cemetery 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final nermonta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): reel(5 Examiner hronic constitution Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseduence of Examiner ears law requires that the death certificate be executed Osteoporosis attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ②No 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No has page 2 s certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🟿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Ryan Childers, M.D. 4940 32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

65-000

Eastern Avenue

Baltimore MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Ivial Registrar		rtificate of Dea			g. No. o	0 21500		
F	Physicia		1. Decedent's Name (First, Middle, Last)	M. ZIM	MERMAN	2	Date of Death Month	Day 1, 200	3. Time of Death 99 1:20 a M		
	/Medic Examin				Arundel						
	uneral rector		6. Social Security Number 212-09-2392 6. Sex 1 ☐ M 2 🗷 F 7. Age	(In yrs. last birthday) 91 Yrs.	If Under 1 Year If Un Months Days Hou		Date of Birth (Month, Day, une 4,	Year) 9. 1918 M	Birthplace (State or Foreign Country) aryland		
Maryland		ctor	Jsual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel			10d. Inside City Limits 1 ☐ Yes 2 No					
h with the	23a or 28 st be ru	al Director	0e. Street and Number 612 Stephanie Court	g. Citizen of Wha	t Country?						
ING 21215-0036 be filed within 72 hours after death with the Maryland ntal Hvoiene.	al", or items 2 Examiner mu	by Funeral	11. Marital Status 12. Was Decedent Every Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	American Indian, Vhite, etc. hite							
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hydiene.	than "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) Housewife	most of working		6b. Kind of Busin			
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Maryia id 2 should th and Mer	Department of Health and Mental Hygiene. Important: if item 271s or 28a-f show any Injury or other traumatic event, Ite Medical Examiner must be realfied at once.	P	19a. Informant's Name/Relationship (Type. Print) Cynthia M. Stivers (Daughter)	City or Town, Sta	ate, Zip Code)						
IMOre, Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 20c. Location - City Cemetery, crematory or other place) Garrison, I									
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/M	physician and edical miner transit the burial-transit	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately list condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Chiefe or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
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Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death cer A hours after death.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	27. Manner of Death 28a. Date of Injury	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
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To the	To th	M	29b. Signature and title of certifies	- us	29c. License num 0 00/6			_	Month, Day, Year)		
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type	105 Disis	tal D.	Cint	ircur he	d		
	Sta Regist			ar's Signature	(-1)						

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	R	- For State legistrar		(Certifica	te of i	Death			R 2. Date of Dea	teg. No.	-		
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Funeral Director	5	5. Social Security Number 591–68–0472	6. Sex	7. Age (In y	rs. last birth	day) Yrs.	If Under 1 Ye Months Da			Co			9. Birthpl Counti FL	
aoy		Usual Residence of Decedent 10a. State 10b. County	,	10c.	City, Town o	r Locatio	n						10	Od. Inside City Limits
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D 2121: should be fil and Mental I 7 is marked natic event,		19a. Informant's Name/Relation	nship (Type, Print)	er			Address (Str	et and Num	ber or Ru	ıral Route Nu		-		p Code)
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Division o To the Hospital or Attending within 24 hours after death To the Ruoeral Director: After completely filled in by the fune	erunca	3 Suicide 6 Co	uld not be 28e. Pla		At home, far	m, street	, factory, office	building, et		28f. Location or Town, Vestbound I				Route Number, City
To the Hosp within 24 hos To the Fuoe completely fi		29a. Certifier 1 Certifying	Physician: To the becaminer: On the basis and manner	of examinat										ause(s)
	Z Z	29b. Signature end title of certif		- MICH.				nse number				ate signed		, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 7 **Physician** 2009 8:30 AM June V. Baker /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Garrett 3412 Swanton Road Swanton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Days Hours Months 1 ☐ M 2 【XF 84 1925 Maryland Director 216-22-5739 May 11, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, I'm M. dical Evantine of the interior and other traumatic event, I'm M. dical Evantine of the interior and one. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2 ▼No Director Swanton MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21561 United States 3412 Swanton Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 _Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify þ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Friend Deloris Sharpless မှ Lemuel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44626 1361 Cricket Hill, SE, East Sparta, OH Mr. Robert Baker, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Marial 2 □ Cremation 3 □ Removal from State 6/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Swanton, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, 21. Signature of Funeral Service Licenses K. atherine 21 N. Second St., Oakland, MD Sweethe Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2ars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed 2 No 1 □Yes 2 K No 1 Yes After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home _2 **Z**No 5 ☐ Residence 6 ☐ Other (Specify) 1∏ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation n 24 hours after death.

ne Funeral Cirector Af
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) Dr. Paul Daniel Miller 69 Wolf Acres Drive, Oakland, MD 21550 31. Date filed (Month Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 18-2009 2:20 A M VIOLET V. BEALL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL CROFTON CROFTON CONVALESCENT & REHAB. CTR. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-15-1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. 1 □ M 2 👿 F 212-64-1479 95 London, England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No Clarksville Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11988 Simpson Road 21029 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 K∑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2X No Specify: Specify: White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alfred Chapman Mary A. Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11988 Simpson Rd. Clarksville, Maryland 21029 Shirley Huffman/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 06-22-09 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hedgman MO1374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Superfield list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Atrial Fibrillation Due to (or as a consequence of): Debilitu 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Exercitant Interpretation of any or other traumatic event, I'm Madical Exercitant Interpretation

Baltimore, Maryland 21215-0036

Examine Physician/Medical 2 Completed

burial-tran attending p sate has been signed by the page 2 should be detached certificate director, Be Certification: To this s after death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9 Unknown Hiatal Hernia

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

JUN 2 3 2009

29a. Certifier

29c. License number 29d. Date signed (Month, Day, Year)

D20108

a Key hours 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, MD 14300 Gallant Fox Lane #222 Bowie, Maryland

State Registrar

filled in by

Medical

24 hours a

within 2.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** kine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner nton Medical Center Fort Washington
If Under 1 Year | If Under 24 Hrs. 4, Date of Bi **Hrince** Ft. Washir Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days 1 □ M 2 F 578-54-4293 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Even ingrass be notified at 1 ☐ Yes 2 No Hexandria Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 7131 Silverlake Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strickland/ 5609 Belleay Woods Lane, Alexandria VA 22315 sisten 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State nowden Cemetery 6/26/09 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Artem), sease Immediate Cause (Final disease or condition resulting in death) theroscleration Coronary **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d þ ia be tes 2 1 No 3 Probably 4 Unknown 1 Tes Completed per tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Dusuf Chroniz Kenal certificate 1 Tyes 2 | No of Vital 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 18, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sachdera, MD-11711 Livingston Rd., Ft. Washington, MD 20744 Deepak

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

JUN 2 3 2009

32. Registrar's Signature

			For State Registrar		State of M	arylan	•	artment rtificate		Health and N <i>Death</i>	nental Hy	ygiene Reg. No	- W) 9	21	b U 4
			1. Decedent's Name	e (First, Middle, L		,					2. Date of D			Voor	3. Time	of Death
	Physici		Har	riet	But	er					Month 06	$\mathcal{A}^{\scriptscriptstyle{D}}$	o s	2009	42	57 M
e de la companya de l	/Medic Examir		4a. Facility Name (li	f not institution, g	ive street and number,)	ME	4b. City, CLIN		r Location of Death		4c	County of	of Death	RGE'S	
	Funeral Director		5. Social Security N 219–46–61	umber 6.	Sex 7. As		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 04-14-	irth Pay Year -1920	3	9. Birthpl Croon	ace (State Try) Ma	or Foreign rylan
	pc ,		Usual Residence of			140- 00	, Town or Lo	estion						1/	nd Inside (City Limits
	Maryla -f shov	tor	Maryland	Prince (George's	10c. City		stvil	le							s 2 No
	h the	Director	10e. Street and Nur	mber				10f. Zip	Code			10g. Ci	itizen of W	hat Coun	ry?	-
	th wil		3217 Walt	ters Lan	e #103				074				USA			
"	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jicel Examble must be incilled at	Funeral	11. Marital Status 1 □ Never Marri	ied 2 K Married	12. Was Decedent Armed Forces' 1 ∐Yes 2 👿	?				Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)				tc.	
03	urs a	b	3 Widowed	4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2	2 K 1N0	Specify:			Specify.	Bla	ck	
2-0	hin 72 ho e. an "natur Modical	ed	(Spec	15. Decedent's l	Education		16a. Dece	dent's Usua	al Occup	pation during most of work	ina	16b. k	Kind of Bu	siness/Ind	ustry	
2121	within ene. than "	Completed by	Elementary/Seco 7th			llege (1-4or 5+)			kind of work done during most of working DO NOT use retired) Domestic			Pri	rivate Indust		ıstry	
larylan	should be and Mental s marked o umatic eve	To Be C	17. Father's Name	(First, Middle, Las mes Smit						18. Mother's Nam Mary B		le, Maidei	n Surnam	e)		
		_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Total 3217 Walters Lane #103 Forestville,													
re,	= =		20a. Method of Disp			20b. P	lace of Dispo				Date		ocation -			
E	Page nent c nt: If ry or			☐ Cremation 3 5 ☐ Other (Spec	☐ Removal from State cify)		ar Hil				-2009	Sui	tland	l, Ma	rylan	ıd
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD									D 207	46			
			23a. Part 1. Enter t	he disease or co	mplications that cause by one cause on each	d the death		ter the mod	le of dyi	ing, such as cardiac	or respiratory	arrest,			Approxim Interval B	ate etween
	Physician		Immediate Cause	(Final	Alzhein		diseas	se							Onset and	d Death
	/Medical		resulting in death)	4	a. Due to (or a											
7	Examiner		Commented to the day	n ditions	Pneumon	iia										
	cuted d ansit	Examiner	Sequentially list colif any, leading to imcause. Enter under Cause (Disease or that initiated events	imediate eriying injury	Due to (or as			ıffic	ienc	у						
,8760,	cate be executed physician and the burial-transit	al Exa	resulting in death)	Last	Due to (or as a consequence of): Old Cerebrovascular Accident											
387		dical			d											
O. Box 6	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months? No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	☐ Ectopic p ☐ Other <i>(sp</i>		су			23d. Dat Mo	e of delive	ery Day	Year
ds, P.	uires that the de signed by the a d be detached to	þ	_		contributing to death								use cont		ie cause o ably 4 [of death?
Vital Records,	e law requires t has been signe je 2 should be e	Completed	Cardiomyopathy with chronic atrial fibrillation 1 Yes 2 No 3 24a. Was an autopsy production 24b. Was graduated by the chronic atrial fibrillation 24b. Was an autopsy production 24b. Wa									Were auto	psy finding npletion o	s available f cause of		
<u>=</u>	r: Th icate r, pag												lo .	l∐Yes	2 □No	
Ζį	Physician: The la this certificate ha al director, page?	a	25. Was case refer examiner?	,	Hospital:				Ot	26. Place of Dea						
of	gisi g	ايا ايا	1 ☐ Yes 2 🔀 27. Mapner of Deat	-	1 ∐ Inpat		ER/Outpatie		DA 28c. Inju	4 A Nursing H	ome 5 ☐ Re 28d. Describ				y)	
on	ding h. Afte fune	tiol	1 Natural 2 ☐ Accident	5 Pending investigati	(Month, D	ay, Year)	Injury	М	Wo	rkí? ∐Yes 2. □No		•	•			
Division	or Attending after death. Director: Afte in by the fune	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	be 28e. Place of Ir	njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, factory	, office		28f. Location City or T	(Street a own, Sta	and Numb te)	er or Rura	l Route No	ımber,
_	o the Hospital or Attending Phithin 24 hours after death. o the Funeral Director: After it completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one)	1 X Certifying 2 Medical Ex	Physician: To the bes aminer: On the basis and manners	of examina	owledge, dea ation and/or i	th occurred ovestigation	at the f	time, date and place opinion, death occu	e, and due to the arred at the tim	he cause e, date a	(s) and mand place,	anner as s and due to	tated.	e(s)
	ithin 2	Mec	29b. Signature and	I title of certifier	7) and marriers	4		290	c. Licen	se number		29d. D	ate signe	d (Month,	Day, Year))

Division of Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f

State Registrar

31. Date filed (Month, Day, Yea
JUN 2 3 2009

29b. Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alain G. Champaloux, MD 14314 Old Marlboro Pike 32. Registrar's Signature

DHMH 17 Rev 1/2001

D042049

June 22, 2009

Upper Marlboro, MD 20772

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columhia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Social Security Number 1**X** M 2□ F Months Days Director 579-34**-**0950 80 10/03/1928 MA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinat must be a will add 1 ☐ Yes 2 No Director Ellicott City Howard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 21043 United States 8426 Jopenda Drive permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examinations in the medical Examinations. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Completed by Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD (WSSC) Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar S. Bennett Sr. Florence White ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar S. Bennett III - son 8426 Jopenda Drive Ellicott City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 06/24/09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee M00845 4112 Old Columbia Pike Ellicott City, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac yr respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence 4): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Nav Examiner ue to (or as consequence Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 27b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perforn certificate 1 □Yes 2 No 1 □ Yes 2 DN 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To of 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera Division 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8,10e, & 19b, per Fh g893 7/15/09 TT
State of Maryland Department of Health and Mental Hygiene amend #6 Per FH G893 7/28 10 The of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 21, 2009 **Physician** June 8:20 p^M Helen P. Brewer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Hillside House Clarksville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **05** (Month, Day, Year) 06/25/1921 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 M 88 Oklahoma 525-20-2759 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itams on other traumatic. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number Le United States 21075 7262 Peeble Creek Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡ No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Self-employed Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Lee Pearl Christopher Lewis J. Grantham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pebble 19a. Informant's Name/Relationship (Type. Print) Peeble Creek Dr. Elkridge, MD 21075 7262 Rod Brewer - son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/2009 | Hanover, MD Ardent Crematory 4 □ Donation 5 □ Other (Specify) 21. Sign nure of Fun ral Service Li ensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Response on the condition of the condition of the cause of the cau Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cause stally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine VASCULAR ALCOBNI Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Nonknown Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed ERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ASSISTED LIVING 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? e Hospital or Attending F 24 hours after death. P Funeral Director; After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/22/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1534 King William Drive Catonsville, MD 21228 Muhammad Adbullah 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 3 2009

Registrar DHMH 17 Rev 1/2001

State

barker)

			For State Registrar	State of Ma	•	epartment of r Certificate of			gierie Reg. No	2000	21607	
	Dharatat		1. Decedent's Name (First, Middle, Lat	•					ath Da	ay Year	3. Time of Death	
	Physici /Medic		Robert	Berr	7.5'r.			Month 6	1	9 09	10:00 pM	
	Examin		4a. Facility Name (If not institution, giv				r Location of Death	n		. County of Dea		
-			Charlestown Retire	117		Catonsv:	LILE Tif Under 24 Hrs.	Doto of Piri		Baltimor	thplace (State or Foreign	
	Funeral Director		235-20-0431	E M OF C	(In yrs. last birth	rs. Months Days	Hours Min.	8. Date of Birl (Month, Da 08/17/	1917 1917	West	ountry) Virginia	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	Mary f sh	to	MD Baltimo	re	Catons	ville					1 ∐Yes 2 x No	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Co	ountry?	
	th wit	al D	719 Maiden Choic	e Lane		212	28	τ	Unit	ed Stat	es	
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1942-	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, Whit		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. viter than "natural", or items 23a or 28a-f show ant, th. M. dical Evan, nor i out be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	N Tyes 2 N If Yes, Give Year or Dates:	1946	1 □Yes 2 ½ No				Specify: W	hite	
5-(72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. I	Decedent's Usual Occup Give kind of work done	pation during most of wor	king	16b. K	Kind of Business	/Industry	
121	within ene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Physician	e kind of work done during most of working DO NOT use retired)				re	
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an	ould be filed withi Mental Hygiene. arked other thar atic event, Im. M	To Be	Andrew Wirt Ber				lay Zinn					
Maryland	nd 2 sho alth and 27 is m r traum	-	19a. Informant's Name/Relationship (Dr. Robert Berry,			Mailing Address (Street 5 Bear Fore		ural Route Numb Hanover				
Ē,	s 1 al of He item othe		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other pla	ce)	Date	20c. L	ocation - City or	Town, State	
Ĕ	Page nent c ant: If ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			ods Cemeter	1 (12)	9/2009	Fla	atwoods,	, WV	
Baltimore,	permit. Pages 1 Department of F Important: If ite any Injury or ot		21. Signature of Funeral Service incer	MO:	1411	22. Name and Addres	110				mily F.H.Inc , MD 21043	
			23a. Part/l. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no						Approximate Interval Between	
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-	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
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	uted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	<i>J.</i>						
~	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of	r):				<u></u>		
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	rtifica ng ph as th		15.551111.5									
O. Box	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of 1 ☐ Live birth 1	су			23d. Date of delivery Month Day Ye				
σ.	that ned b deta		Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did 1	23e. Did tobacco use contribute to the cause			
rds	quires en sign uld be	ed by						1 🗆 '	Yes 2	2 □ No 3 □ F	robably 4 Unknown	
Vital Records,	law requir as been s 2 should	Completed						24a. Was		24b. Were a	utopsy findings available completion of cause of	
Ĕ.	The I	E O					•	autoj perfo 1 □ Yes	rmed?	_ death?	s 2 🗆 No	
/ita	slcian; Th certificate rector, pag	Be (25. Was case referred to medical examiner?					ath (Check only o				
of \	Physician: r this certific ral director, I	ျ	1 ☐ Yes 2 ☑ 1√No	L ,		patient 3 DOA		lome 5 ☐ Resi			ecify)	
n C	ding F h. After funera	Certification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Ti (<i>Year</i>) In	jury Wo	ryat rk?]Yes 2 ∐No	28d. Describe	how inju	ary occurred		
Division	eat or:	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 200 Diago of Inju	rv - At home, far		1162 5 110	28f. Location (Street a	and Number or F	Rural Route Number.	
Θ̈́	after d after d Direct	erti	4 ☐ Homicide determined	building, etc	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b					death occurred at the t						
	he Ho in 24 he Fu	Medical	one)	and manner sta		l/or investigation, in my	opinion, death occ	urred at the time,				
	Vith Vith Com	Σ	29b. Signature and title of certifier	_		29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)	
	$\overline{}$		Kleneer	Bowl	in 10	US DY	4377		4	12210	> 5	
18	الم		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)		0 1	,	3/0	21228	
3	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	r's Signature.	ath Choi	ce Lar	ne, Ca	ton.	suille,	my	
	Registr		JUN 2 3 2	009 Comen	n B.	Type, Print) der Choi						

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He rtificate of D		F	Reg. No.	009	21608		
	Physici /Medic		Decedent's Name (First, Middle, La	2. Date of Dea Month 06	27	Year 09	3. Time of Death 0810 A M						
The state of the s	Examin		4a. Facility Name (If not institution, given WMHS-BRADDOCK C		4c. County of Death ALLEGANY								
	Funeral Director		5. Social Security Number 213-16-9248		(In yrs. last birthday) 86 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Septemb	h y, Year) per 02, 19	9. Birth Cou	place (State or Foreign Maryland		
	show	'n	Usual Residence of Decedent 10a. State 10b. County	Hanny	10c. City, Town or Lo		Cumberland				10d. Inside City Limits 1 XYes 2 No		
	with the N 3a or 28a-f	I Director	10e. Street and Number	Maryland Allegany Oe. Street and Number 528 Washington Street			21502		10g. Citizen of What Country? USA				
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Item Experies must be rediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1	ver in U.S. 13.		as Decedent of Hispanic Origin? (Specify Yes or No res, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: Whit			
21215-0036	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind	of Business/Ir	ndustry		
	filed within Hygiene. other than " ent, tre Me	Comp	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Secretary				edical		
land	ild be fili fental H ked oth iic even	To Be	17. Father's Name (First, Middle, Last) Wilson Bradley					(First, Middle, Maiden Surname) Eva McCormick					
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modral Experience must be neather anone.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or						al Route Number, City or Town, State, Zip Code) eet, Cumberland, Maryland, 21502				
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemetery, crer	20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory Date June 28, Cumberland Crematory 2009					Cumberland, Maryland		
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	ihluha	m 22	2. Name and Address 8 Eas	of Facility at Main Stree			Kenzie Fung, MD 21	uneral Home P.A. 1539		
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line a. Hyp	the death. To not ente.	ter the mode of dying,	, such <i>a</i> s cardiac d	or respiratory ar	rrest,		Approximate Interval Between Onset and Death		
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dus to (or ac a	ule an	eamiq.	1 .						
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of): Blee	ed.	<u>eluve</u>						
.O. Box 68	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown					te of delivery nnth Day Year					
rds, P.	quires that en signed b uld be deta	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						23e. Did tobacco use contribute to the cause of de				
Vital Records,	ian: The law requii rtificate has been s tor, page 2 should	Completed						perfo	Was an autopsy performed? death? 24b. Were autopsy findings average death? 1 □ Yes 2 ☒ No				
Vita	ysician; iis certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ☐ ER/Outpatie	Other	26. Place of Death			Other (Spec	nife)		
ion of	nding Phy ath. r: After thi e funeral c	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Injury Work?		28d. Describe I			"")		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification:	3 ☐ Suicide 6 ☐ Could not I determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	he Hospit in 24 hour he Funera pletely fille	Medical (Physician: To the best of miner: On the basis of and manner sta	examination and/or in								
	To t To t	Σ	29b. Signature and title of certifier	Lacem	MD.	29c. License	66150	5	29d. Date	27/C), Day, Year)) G		
	Sta	te	30. Name and address of person who Muhammad A 31. Date filed (Month, Day, Year)	lacem Mi	eath (Item 23a) (Type, 0 625 Ke) ar's Signature	1 1	e, Cum	berlar	id M	arylar	d 21502		
DHN	Registr MH 17 Rev 1/2	rar		2009	a p. A	rand				1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 21609

		- For State		C	ertificate	of Deat	h				Reg. No.				
Physicia	n/	 Decedent's Name (First, Middle 								. Date of De Month	Day	Year		Time of Death	
ledical Examir	ner	Wilfred Wil	lis Cav	ender						June 24,	2009			12011118	
		4a. Facility Name (if not institution	-	d number)	-			ocation of	Death			c. County of Washingt			
		16040 Spielman Road	<u> </u>				msport							Jane (Otata es F	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs) If Undo	s Days	If Under Hours	Min.		,	1	Coun	olace (State or Fo try)	
Director		219-12-1835	1 X M 2	F 84	Į.	Yrs.	3 Days	110010		11/19	3/19	24	West	Virgir	11a
	t	Usual Residence of Decedent											12	Od Jacida City I	imita
any		10a. State 10b. County		10c. Ci	ty, Town or L	ocation							1	0d. Inside City L	_ i
nd show	<u> </u>	Maryland Was	shingtor	1	V	Villian	nspor	t							ZINO
Aaryland 28a-f show 1 at once.	హ	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of Wha	at Countr	y?	
the N	Director	16040 Spielma	an Road				2	1795				Ţ	JSA		
with rs 23; re no	<u>a</u>	11. Marital Status	12. Was	Decedent Ever in	U.S. 13	. Was Decede	ent of Hisp	anic Origi	in? (Spe	cify Yes or N	N O-	14. Race - White,		n Indian, Black,	
leath	Funeral	1 Never Married 2 M	larried 1 X Y	ed Forces? es 2 No	, [If Yes, speci	ry Cuban,	mexican,	Puerto R	(ican, etc.)		vviite,	, 610.		
fler of	by F	3 Widowed 4 X Div	vorced If Yes, Giv		I 1	Yes 2			_			Specify:			
ours a	흥	15. Decedent's Education (Spe	ecify only highes	grade completed		edent's Usual					16b.	Kind of Bus	siness/Ind	dustry	
72 h	eted	Elementary/Secondary (0-12)	Colle	ge (1-4 or 5+)		•		50		/					
5-0036 ed within 7/ tygiene. other than	dwo	7				Owr	_						o Rej	pair	
5-0 led w Hygic othe	O	17. Father's Name (First, Middle					1			First, Middle					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ	Charles Elme	The second second	ender				Ber				Messe			
	၉	19a. Informant's Name/Relations			1	ailing Addres									- 1
MD td 2 sho tilth and m 27 is aumat		Cheryl L. Bass	s - Daug		1	3 Vale			ager	Date		Location -		21740 own State	-
S l ar		20a. Method of Disposition 1 X Burial 2 Crematio	n 3 Remo			or other place		netery,		Daio				,	
E 4 0 E 1		4 Donation 5 Other S	Spenify:/			vn Mem.				9-2009		illiar	nspo	rt, Mary	/lan
Balti permit. Departm Imports	Ī	21. Signature of Funer / Servic	Licensee		1	EDOEPE									
E.E.S.B.		in/le	81											, MD 217	
Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications t	hat caused the de	ath. Do not er	nter the mode	of dying,	such as ca	ardiac or	respiratory	arrest, s	hock, or hea	art	Approximate In Between Onse	
/Medical caminer	1 4	Immediate Cause (Final disease	Cantan	t Gunshot Wo	ounds (2) c	of Head								Death	
tailillei		or condition resulting in death)	Due to (o	as a consequenc	e of):										
	니	Sequentially list conditions,	b	r as a consequenc				_	-	_	_				-
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		r as a consequent	e or).										
	a	(Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequent	e of):										
executed an and al - transit			d		 										
al an	//Medical	UNPENDED	AMEN	DED											
760, ficate be exe g physician a	Š	IF FEMALE:		yes, outcome of p							2	23d. Date of	,		
687 ertific ding	an/	23b. Was decedent pregnant in past 12 months?	1 -	Live birth Pregnant at time c	f 1 - 16-	Fetal deati		Ectopi	c pregna	ncy		Month	D	ay Yea	ar
P.O. Box 68' that the death certifined by the attending detached for use as	Physiciar	1 Yes 2 No 9 U	nknown T	Unknown	r death 5	Other (Sp	ecify)								Ì
the de	된	Part II. Other significant cond			ot resulting in	the underlying	ng cause o	given in Pa	art I.	23e. Di	id tobace	co use contr	ibute to t	he cause of dea	th?
P.O. res that to signed by be detac	by	, are in our or organization				,				1	Yes 2	√ No 3	Prob	ably 4 Unki	nown
S, F quires en signald be	per									24a. W	as an	24b. \	Were aut	opsy findings av	/ailable
cords, law requir has been s	Completed										utopsy erformed		prior to c death?	ompletion of cau	ise of
Rec The la	mo:										es 2 _	No 1	✓ Ye	s 2	No
tal Re	യ	25. Was case referred to medic	_				26.Place	e of Death							
Division of Vital Records, P.O. Box 68760, rol or Attending Physician: The law requires that the death certificate be re after death. al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	O B	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outp	atient 3	DOA	Other ₄		g Home 5		idence 6		Scene	
ing Pt After unera	L.	27. Manner of Death	28a	Date of Injury (Month, Day, Year) UND:	28b. Tin FOUN	ne of Injury	1	ıry at Worl		28d. Descri Subject s		injury occuri elf	red		
ion tendi eath. for: /	atio			124, 2009	1100 h		1	Yes 2 ✔	No	==			-		
0 < 2 3 6	Ę		uld not be	. Place of Injury -	At home, farm	, street, facto	ry, office t	building, e	etc.					ral Route Number	er, City
Divis	Certification:	4 Homicide	termined (Sc	ecify) Single I	amily					16040 Spi	elman l) Road, Willi	iamspoi	t, MD	
F F		29a. Certifier (Check only 1 Certifying	Physician: To t	ne best of my know	wledge, death	occurred at t	he ti me , d	ate and pl	lace, and	due to the	cause(s)	and manne	er as state	ed.	
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	Medical	one) 2 Medical Ex	and <u>ma</u>	pasis of examinati nner stated.	on and/or inve	estigation, in	ny opinior	n, death o	ccurred a	at the time, o					
F 3 F 8	Me	29b. Signature and title of certi			1	2		se number	г		- 1			nth, Day, Year)	
		(1111	1 1	9/1	7		O.C.	M.E.			J	une 25, 2	2009		
		30. Name and address of person	on who complete	d cause of death	Item 23a)										
DH2+1		Zabiullah Ali, M.D.		ledical Exami		Penn Stre	eet, Bal	timore,	MD 21	201					
·	tate	31. Date filed (Month, Day Yea	00000	32. Registrar's Sig	nature ,	,									
Regis		1 11 N 2	n ZIIIY I	12	A	back	1				OCME				

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Danastment of Houlth and Marital Haviana Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	State of Maryland		artment of H		Mental Hy	giene Reg. No. 2	0.0	01310					
	Registrar 1. Decedent's Name (First, Middle, Last)		Timodio or E		2. Date of De	-	Year	3. Time of Death					
ian cal	Jean T. Culver				June	20, 20	09	3:30a M					
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County		****					
	Magnolia Center 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	Prince	9. Birthp	place (State or Foreign					
	579-28-9909 1□M 2対F 82	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D. 9-9-19	26 Yea <i>r)</i>	Wash	ington,DC					
	Usual Residence of Decedent	T out o	antina	<u> </u>			1	0d. Inside City Limits					
'n	10a. State 10b. County 10c. City,						'	1 Yes 2 □ No					
Director	MD Prince Georges Hya 10e. Street and Number	ttsvi	10f. Zip Code		1	10g. Citizen of \	What Cour	ntry?					
ā	5609 Elberton Court		2078	81		United							
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	o- 14. Rad	e - Americ	can Indian,					
	1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give		1 ☐Yes 2 ☑ No	Specify:	0 1 1104.11, 0.10.1)								
g D	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	160 Door	dent's Usual Occupa	ation		16b. Kind of B	Whit						
Slete	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of wor.	king	l los. Kind of B	00110007111	adotty					
Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Sta	age Hand			Loca1	22						
D P	17. Father's Name (First, Middle, Last)				•	e, Maiden Surnan	ne)						
0	T. Clarence Trundle			Helene	Anadal								
	19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street a</i> Chester Vi					o Code)					
	Teresa Culver/ Daughter 20a. Method of Disposition 20b. Pla	ce of Disn	osition (Name of	1	Date	20c. Location		own, State					
	4 D Buriel 2 By Cramation 2 D Bamayal from State Cel		matory or other place oln Crema		24-2009	Brentwo	od, M	Œ					
	21. Signature of Juneral Service Ligensee	2	2. Name and Addres	ss of Facility Fo	rt Linco	oln Fune	ral H	Home					
	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						20/2	Approximate Interval Between Onset and Death					
	disease or condition		Colon Can	cer				months					
	resulting in death) Due to (or as a consequence of): Failure to Thrive												
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the conditions of the conditio		IIIIIve					months					
Examiner	I triat irritiateu everits												
	resulting in death) Last Due to (or as a conseque	ence of):											
dica	d												
Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnan	су				23d. Da	ate of deliv	very					
Clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 1 ☐ Yes 2 ☑ No		☐ Ectopic pregnanc ☐ Other (specify) _	У			onth	Day Year					
nys.	9 Unknown												
by P	Part II. Other significant conditions contributing to death but not result	ting in the	underlying cause give	en in Part I.				the cause of death?					
						Yes 2 X No		bably 4 Unknown					
Completed					24a. Wa aut	s an 24b. opsy formed?	Were auto prior to co death?	opsy findings available ompletion of cause of					
					1 ☐ Yes	2 X No	1 ☐ Yes	2 □ No					
0	25. Was case referred to medical examiner? Hospital: Hospital:	D/Outnotic	ont a Door Oth	26. Place of Deler: 4 Nursing F			hor (Casa	(6.1					
2		28b. Time	of 28c. Injur	ry at		how injury occur		iiy)					
200	1 1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	M 1 🗆	Yes 2 □No									
ermicanoni	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, s	treet, factory, office			(Street and Num own, State)	ber or Rui	ral Route Number,					
)	29a. Certifier 1 ★ Certifying Physician: To the best of my know	ledge des	th occurred at the ti	me date and place	e and due to th	e cause(s) and n	nanner as	stated.					
edical	(Check only one) Certifying Physician: To the best of my know and manner stated.	on and/or i	investigation, in my o	opinion, death occ	urred at the time	e, date and place	, and due	to the cause(s)					
	29b. Signature and title of certifier	· ·	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)					
	M Nakajn autor	M	N 2	0108		0/.	12/	107					
	30. Name and address of person who completed cause of death (Item 14300 Gallant Fox Lane #222, Bo												
,	31. Date filed (Month, Day, Year) 32. Redistrar's Sunatu		לנו עניו עניו										
te ar	JUN 2 3 2009 Server 32. Registrar's squate												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** A M 5:00 Malcolm Edward Chapman June 18, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6006Riverside Drive Prince George's Riverdale 8. Date of Birth (Month, Day, Year 08-04-1921 9. Birthplace (State or Foreign Couptry) Beards Fork, WV 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**C**X**M 2□ F 87 **Director** 233-28-2940 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the M dical Ex miner must be notified at 1 Yes 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6006 Riverside Drive 20737 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: þ ¾ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Supervisor DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Garnet Chapman <u>Zelma V. Todd</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Riverside Dr. Riverdale, MD 20737 Dixie L. Cobb/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any injury or ot
once, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 106-22-2009 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee Mary Hedgman Mo1374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Renal Cell Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Chronic Obstructive Pulmonary Disease Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2. No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O. s after death within 24 hours at To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASILLY

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 06 09 JOSEPH WESLEY COOPER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 **X**M 2 □ F 10/28/48 NORTH CAROLINA 218-48-7954 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show event, the Medical Expresser count by notified at 1 ☐Yes 2☐ No Director ACCOMACK **NEW CHURCH** VΑ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 29299 TYLER DR. 23415 USA items 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status within 72 hours after 1 □Yes 2 Xo If Yes, Give 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify. BLACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) LABORER JANITORIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ex JOHN A. STEAD MARGARET SCHOOLFTELD ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOWANDA E. COOPER, DAUGHTER P.O. BOX 163 ATLANTIC, VA 23303 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) JOSEPH HOLINESS L06/27/09 ATLANTIC, VA 22. Name and Address of Facility 21. Sixture of Funeral Service Licensi COOPER & HUMBLES FUNERAL CO., ACCOMAC. VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? ves 20No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1X Yes 2 ☐ No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2

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31. Date filed (Month, Day, Year

29b. Signature and title of de

F Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

My

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 June 21. 5:10 A M Harriet Mae Craig 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Brighton Gardens North Bethesda If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 □ M 2 🔀 F Months Days Hours 1922 Dec 25, Ohio 278-14-8085 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2√☐ No MD Kensington Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20895 3555 Raymoor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 24 No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Battenberg Clarence Earl Rossell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3555 Raymoor Rd. Kensington, MD 20895 Constance E. Craig/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 06/22/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Golffa Hottles Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Hypertension District for the a consequence of Breast Cancer Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? Raynaud's Phenomenon 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No 2 🗆 No 1 □Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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Funeral

Director

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Department of Himportant: If ite any injury or ot once.

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Pneumonia

25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1X Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Mont

5 Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6X Other (Specify) living 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature an

29c, License number D53691

29d. Date signed (Month, Day, Year) June 22, 2009

s of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Ajay Reddy, M.D. 3200 Tower Oaks Blvd. #110 Rockville, MD 20852

State Registrar

Registrar's Signatur 2009



			Type or Print in Bl State of Maryland					-	ible.
		for State Registrar	,		tificate of L		,	Reg. No.	109 21614
		1. Decedent's Name (First, Middle, La					2. Date of De	eath	3. Time of Death
Physic /Med		William Keith	Clark				June	18, 200	9 6:58 a M
Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	1	4c. County	y of Death
A Company of the second		Laurel Regional	-		Laurel				ce George's
Funeral Director		578-22-5377	Sex 7. Age (In yrs. la 1x M 2 F 86	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Day May 14	1923	9. Birthplace (State or Foreign Country) New York
iryland thow		Usual Residence of Decedent 10a. State 10b. County		Town or Loca					10d. Inside City Limits
ne Ma 8a-f s	cto		tgomery	Silve	r Spring				1 ☐ Yes 2 🔀 No
th with the 23a or 2	Funeral Director	10e. Street and Number 9506 Saybrook A	venue		10f. Zip Code	0901			What Country? USA
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	/ Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1€2\$Yes 2 □ No If Yes, Give	11	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 XNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rad Bla Specif	ce - American Indian, ack, White, etc. fv: White
ours ural", I Exa	d by	35€Widowed 4 □ Divorced	Year or Dates: WW11						.,,
d 2 should be filed within 72 hours aft the and Mental Hygiene. 72 Is marked other than "natural", or traumatic event, the Medical Exami	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. Di	ent's Usual Occupa ind of work done of O NOT use retired, SS Admin	luring most of wor)	king	Johns	Business/Industry Hopkins Applied
be filed water Hygie	S	17. Father's Name (First, Middle, Las		Dusine	SS AUMILII.	18. Mother's Nan	oe /First Middle		es Lab
should be f and Mental b marked of umatic ever	To Be	Russell Clark				Sadie		, waiden Sumai	ne)
mit. Pages I and 2 sho partment of Health and I portant: If Item 27 Is ms y injury or other traums	ľ	19a. Informant's Name/Relationship William J. Clar			Address (Street a Verdi Co				n, State, Zip Code) 20904
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, the Medical Examiner must be notified at any inJury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Speci	Removal from State	metery, cremi	ition (Name of atory or other place tan Crem	·	Date une 18, 2009		- City or Town, State
permit. I Departm Importal any inju		21. Signature of Funeral Service Lice			Name and Address	s of Collylin	s Funer	al Home	Inc.
		23a. Part1. Enter the disease, or cor	nplications that caused the death.						Spring, MD 2090
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. Coronary Art						Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque						
	<u>.</u>	Sequentially list conditions,	b. Hypertension Due to for as a conseque						
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	and to got do a control and	noo day					
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The law requires that the death certificate it has been signed by the attending physicage 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of dea	death 3□8	Ectopic pregnancy Other (specify)			1	ate of delivery onth Day Year
that t ed by detac		Part II. Other significant conditions	contributing to death but not result	ting in the und	derlying cause give	en in Part I.	23e. Did	tobacco use con	ntribute to the cause of death?
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w require been stand	ete				GI IIVII	11401011)	04- 14-	041	Manage Assess Reviews and Parking
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physic this cal	2	1 Yes XXNo	Hospital: 1 Inpatient 2 E			4 Li Nursing n		idence 6 D0tl	
ding I	Certification:	27. Manner of Death **XXINatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury		rat ? ∕es 2 □ No		how injury occur	
tal or Attenders after death	Certifi	4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, tarm, stree	et, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my know miner: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) and m , date and place	nanner as stated. , and due to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License			_	ed (Month, Day, Year)
15+1		1.06	am, 1		D6	7320		June	18, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Izuchukwu Obi, MD 7300 Van Dusen Road, Laurel, MD 20707

State Registrar 31. Date filed (Month, Day, Year)

JUN 22 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 6 16 10:04a Doris L. Dorsey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges 8128 Comet Dr Ft. Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/17/37 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Year) Months 1 □ M 2 🛣 F 72 Washington,DC 577-48-3304 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No Ft. Washington Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 USA 8128 Comet Dr Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospitality 10th Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Wills Doris B. Fredericks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13600 Hillrod Lane Upper Marlboro, MD 20774 Kevin Dorsey/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/09 Resurrection Cem. Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature Funeral Service Licen 3401 Bladensburg Road, Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease a complications that eaused to shock, or heart failure. List only one cause on each line tions that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CORONATZY Due to (or as a consequence of): IABETES Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once.

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ther traumatic event, it a Nacical Examinat must be redified at

Examin burial-trar physician sthe burial Physician/Medical attending p for use as t certificate has been signed by the irector, page 2 should be detached ≥ Completed funeral director. Be Certification: To this After after death.

I Director: A d in by the fu filled in by

Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔊 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year JUN 2 3 2009 State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN SETGES MP 6104 DED BRAN 32. Registrar's Signature

24 hours a

within 24 hor To the Fune

Medical

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

	Physicia /Medic Examin	a
<u>/</u>	Funeral Director	

death with the Maryland items 23a or 28a-f show ingraust be notified at Pages 1 and 2 should be filed within 72 hours after ត់ th and Mental Hygiene.
7 is marked other than "natural", or traumatic event, the "matical Evon.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Health tem 27 i

permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other: 000ce.

other

physician and is the burial-trans as attending for use as certificate has been signed by the irector, page 2 should be detached After this after death neral Director: /

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral D completely filled i To the I within 2 1041

Division of Vital Records, P.O. Box 68760,

2. Date of Death 3...Time of Death 1. Decedent's Name (First, Middle, Last) Month Day June 20, 2009 12:00 PM Donald Edward Deaton, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 22904 Woodfield Road Gaithersburg 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 XM 2 □ F Sept 13, 1945 Kentucky 401-60-6537 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Gaithersburg Director MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 20882 22904 Woodfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1967–68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) **5+** Elementary/Secondary (0-12) Public Safety Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie Hornsby Charles B. Deaton ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Mill Creek Ave. Canton, GA 30115 Donald Edward Deaton, Jr./son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 06/23/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 1 MONTh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous Cell Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1X Yes 2 No 3 Probably 4 Unknown Adenocarcinoma of Esophagus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of June 22, 2009 D57896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Road #100 Bethesda, MD 20817 David W. Hirshfield, M.D. Registrar's Signature State Darker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1105 1 N. KATHRYN IRENE DEAL 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LUCGANY COMBERLAND MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) 6. Sex **Funeral** Days Hours 1 □ M 2 🔀 F Yrs. PENNSYLVANIA 99 03-06-1910 **Director** 218-24-8338 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Director FROSTBURG ALLEGANY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21532 U.S.A. 18200 BORDEN YARD ROAD NW Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No à If Yes, Give Year or Dates: Specify: 3 ₩Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other thar other traumatic event, The M BOARD OF EDUCATION CUSTODIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLET MAE SHORT HOUSE JOHN WILLIAM HOUSE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19919 LONACONING ST., MIDLAND MD 21542 HAZEL EAGAN DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MICHAEL'S CEM. 07-02-09 FROSTBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. Sowers m00547 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** bro Vasul disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and I birector by the prevent director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖪 No 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral C

completely filled The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNIL GUPTA M.D.

DIC

00033280

625 Kent AVENUE, COMBERLAND MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Maryland			1 - State Registrar				Certifi	icate of De	eath		Reg. No.	UUJ	410
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month_ **Physician** EVIANS KICHARD 2056 PM JUNE 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 63 **Director** Sept. 1, 1945 Maryland 217-44-207] Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Ewell Maryland Somerset 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō Funeral 20912 Caleb Jones Road 21824 USA or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White 1 Yes 2 No Specify If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4 or 5+) Computer Programmer Campbell's Soup Co. or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Emory L. Evans
19a. Informant's Name/Relationship (Type. Print) Mary Jane Evans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Richard Emory Evans (Son) 34 Village Drive - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 🗌 Other (Specify) Sunnyridge Memorial Park June 22, 2009 Crisfield, Maryland 21. Signature of Euneral Service Lic 22 Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Mary Been Bradsha 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): ARRYTHMIA **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical eral Director; After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Wiknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 4 \square Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury Time of 28c. Injury at Work? 28d. Describe how injury occurred 28b. (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 □ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide hours after within 24 hours a 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (check only one) 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MATali JUNE, 17, 2009 REC-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State JUN 23 2009

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Vear Month STEPHANIE GUADALUPE FRYE JUN 10 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) Months Hours 1 □ M 2 □ X "unascertain" June 8, 2009 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Virginia Fairfax Fairfax 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12105 Pine Forest Circle, Apt. G 22030 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Tho If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 "never employed" "infant" 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeffrey E. Frye Iris Nieto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Roselawn Memorial Gdns 06/23/09

12105 Pine Forest Cir, Apt G, Fairfax, VA

Date

20c. Location - City or Town, State

Princeton, WV

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Marked once. **Physician** /Medical

Physician

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

ş

Completed

Be

Jeffrey E. Frye/Father

4 ☐ Donation 5 ☐ Other (Specify)

1 ₺ Burial 2 ☐ Cremation 3 ₺ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LTC

32. Registrar's Signature

AGNES SIEROCKA-CASTANEDA

31. Date filed (Month, Day, Year)

20a. Method of Disposition

death with the Maryl

filed within 72 hours after

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f shovevent, the Madical Experience must be retilised at

/Medical

Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 attending physician signed by the a peen has

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

21. Signature of Funeral Service L	ho1255	22. Name and Address of Facility Danzansky-Goldber 1170 Rockville Pi	g Memorial Ch ke, Rockville	apels, Inc. , Maryland 20852
shock, or heart failure. List of		not enter the mode of dying, such as card	liac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	_a EXTREME PRI	MATURITY		Onoor and Boarn
resulting in death)	Due to (or as a consequence	A DESCRIPTION OF A STATE OF		
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b Due to (or as a consequence	of):		
Cause (Disease or Injury that initiated events resulting in death) Last	c	of):	. —	
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditio	ns contributing to death but not resulting i	n the underlying cause given in Part I.		se contribute to the cause of death? No 3 □ Probably 4 □ Unknow
		***************************************	24a. Was an autopsy performed? 1 ∐ Yes 2 및 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred to medical examiner?		26. Place of D	Death (Check only one)	
1 Yes 2 No	Hospital: 1 🙀 Inpatient 2 🗆 ER/O	utpatient 3 ☐ DOA Other: 4 ☐ Nursin	g Home 5 Residence 6	i ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day, Year)	Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		urm, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one) 1 Certifyin 2 Medical I	g Physician: To the best of my knowledg xammer. On the basis of examination a and manner stated.	e, death occurred at the time, date and pl nd/or investigation, in my opinion, death o	ace, and due to the cause(s) ccurred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifler	V Vy r	29c. License number	29d. Date	e signed (Month, Day, Year)

20b. Place of Disposition (Name of cemetery, crematory or other place)

State

Registrar

2

acted

D-65419

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** WILMA **JEAN** FAJANS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Plata Medical 0 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 280NE DEC.23,1935 MARYLAND Director 218-30-3280 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD CHARLES COBB ISLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16627 BURLESON DRIVE 20625 S. Funeral Α. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2€No Specify Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOFTWARE ENGINEER GRD INC. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GLENN SNAPP ELIZABETH TURNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) J. ROGER FAJANS/HUSBAND 16627 BURLESON DR.P.O.B.160 COBB ISLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 ALEXANDRIA 28, CREMATORY 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. of Funeral Service Licena M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumani Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 Yes 26. Place of Death (Check only one)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar the as

P.O. Box 68760,

Division of Vital Records,

death with the Marylan

Baltimore, Maryland 21215-0036

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Experient must be notified at

and Mental Hygiene. Is marked other than

Department of Health a Important; If item 27 Is any injury or other trae

Pages 1

attending physician for use ed by the a has director, Be Certification: To funeral After t after death. filled in by the

25. Was case referred to medical examiner? 2 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 ☐ Could not be

Other: 4 \(\Bigcap \) Nursing Home \(5 \Bigcap \) Residence \(6 \Bigcap \) Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

3 Suicide

(Check only one)

29c. License number 000 52919

La Plata

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

James

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State Registrar

Medical

24 hours a

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Clifton Alexander Green 06 09 24 0413 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death WMHS Braddock Campus Allegany Cumberland If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y) Feb. 14, 9. Birthplace (State or Foreign **Funeral** Year) 1919 West Virginia Months Days Hours 1**X** M 2□ F 90 220-03-7639 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Piedmont XYes 2 □ No Director Mineral WV. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 26750 104 Erin St. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No WW 2 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2√2No Black Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) Custodian unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 Is merked oth any liviry or other treumatic eveni ange. Be Davis Price Annie Addison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11800 Hanover Road, Cincinnati, Ohio Clifton Green/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Keyser, West Virginia Potomac Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wagne 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Plnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of spital or Attending Phours after death, neral Director: After the filled in by the funera 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN 26

WAISH ROAD, CUMBERLAND, MD 21502

		For State Registrar	riease	State of M		/ Depa		of He	ealth an	_	l Hygi	_	n n s	21620
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Exam	niner			ve street and number)	-				ocation of E			4c. Couri	ty of Death	
Funan		5. Social Security N	AGNE Jumber 6.		e (In yrs. la:		If Under		If Under 24	Hrs. 8. Date	of Birth		9. Birth	place (State or Foreign
Funera Directo		212-18-2 Usual Residence of	255	1 ∑ M 2□F	90	Yrs.	Months	Days	Hours I	11/0	nth, Day,)2/19	18	Coul	MD
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h wit	alD	9233 Wes	t Stayma	n Drive				210	42		U	nited	State	es
deat	Funeral	11. Marital Status	•	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced	ent of His	panic Origin Mexican, F	? (Specify Ye:	s or No-		ace - Americack, White,	
iryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matte event, the Medical Examinat must be notified at	ρ	1 ☐ Never Marr 3 🗷 Widowed	ried 2 Married 4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:			1 □ Yes 2		Specify:	,	,	Spec		
21215-0036 d within 72 hours aft giene. er than "natural", or in the Medical Exempl	Completed	· · · · ·	15. Decedent's E cify only highest gr	ade completed)		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupat k done du e retired)	ion iring most of	working	1	6b. Kind of	Business/In	dustry
within inene.	omp	Elementary/Second	ondary (0-12) 2	College (1-4or	5+)				lesmaı			Sun L	ife Ir	nsurance
filled Hygother	Be C	17. Father's Name	(First, Middle, Las	t)				1	8. Mother's	Name (First,	Middle, M	aiden Surna	ame)	
Maryland Id 2 should be file Ith and Mental Hy 27 Is marked oth traumatic event	10 B	Herbert	S. Gait	her, Sr.					Cora 1	Pickett	:			
aryla should la marke	1	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street ar	nd Number o	or Rural Route	Number,	City or Tow	n, State, Zij	o Code)
re, Maryla st and 2 should f Health and Mer tem 27 is marke		Saundra	Klinedin	st – daugh	ter	9383	Furro	w Av	. El	licott	City	, MD	21042	2
Or other		20a. Method of Dis		T.D	20b. Pla	ice of Dispo	sition (Nan matory or o	ne of her place)	,	Date	2	Oc. Location	n - City or To	own, State
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Baltimore, permit. Pages 1 ar Department of Hea Important: If Item;	once	21. Signature	un Service ic	see MO	1411	41	2. Name an	d Address	of Facility Lumbia	Harry F	I. Wi	tzke': icott	s Fami	ily F.H.Inc . MD 21043
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Box atth cer attendir	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3[⊒Ectopic p ⊒Other <i>(sp</i>	regnancy ecify)	-				Date of deliv	very Day Year
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tal Rectant The law surfricate has or, pege 2 8	Completed											ned?	prior to co death? 1 ☐ Yes	ompletion of cause of
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本 圧を on of ding Phys After this funeral di	ion: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Natural	th 5 ☐ Pending	28a. Date of Inj (Month, Da	ient 2 □ E ury ay, Year)	28b. Time o Injury	of 2	8c. Injury Work?	at Nurs			w injury occ		ity)
Division of Vital F Division of Vital F To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, peg	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6	28e. Place of In	jury - At hon tc. <i>(Sp</i> ec <i>ity)</i>	ne, farm, str	M reet, factory		es 2□No	28f. Loc	cation (Str y or Town	reet and Nui , State)	mber or Rui	ral Route Number,
Hospita 24 hours Funeral	edical C	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis and manners	of examinati									
Fo the within 2 Fo the comple	Me	29b. Signature and	title of certifier				290	. License	number		29	d. Date sig	ned (Month	, Day, Year)
F \$ F 8			FILA	4.0.10				0	2161	2.		TUAL	E 21	,2009
(241)		30. Name and add	ress of person who	completed cause of	death (Item	23a) (Type,	Print)	۲ .	<u> </u>	/		3 410	ا مار سه	,

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State Registrar 31. Date filed (Month, Day, Year)

JUN 23 2009 900 32. Registrar's Signature

AVENUE, BALTIMORE, MAD 21224 CATOM parked

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 10:05 A.M 2009 T. GORDON June 18, FAYE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brighton Gardens Nursing Home Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y NOV • 12, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Illinois 1 □ M 2 💢 F Nov. Director 322-01-3244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 23a or 28a-f show id other than "natural", or Items 23a or 28a-f shorevent, the Medical Everther must be notified as 1X Yes 2 □ No Bethesda Director Montgomery Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 U. S. A. 5550 Tuckerman Lane death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Office Manager 12 Years 12 should be filed w h and Mental Hygiel 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Levine Harry Teplinsky Pages 1 and 2 should I nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 St. Paul Street, # 12. Brookline, Massachusetts 02446 permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Janie Lewis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nation 2 □ Cremation 3 □ Removal from State Forest Park, Illinois 6/22/2009 4 ☐ Donation 5 ☐ Other (Specify) Waldheim Cemetery 21. Signature of Funeral Service ²Danzanskysg65Tdberg Memorial Chapels, Inc. Dona 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Cardiac Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Chronic Renal Failure certificate be executed and the burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy be detached for in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown σ. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy perfor 2 No 1 □ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No s after death. death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2. To the F and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number June 18, 2009 D30132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14812 Physicians Lane, Suite 161, Rockville, Maryland 20852 Rita M. Ghosh 31. Date filed (Month, Day, Year) State JUN 22 2009 Registrar

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			State of Maryland / Department	artment of Health and N rtificate of Death	after site. It is	0100
			Registrar 1. Decedent's Name (First, Middle, Last)	inicate of Beath	Reg. No.	3. Time of Death
	Physicia		Charles Richard Alsop Gilbert		Month Day Year June 18, 2009	
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
,,,	LAGIIIII	e.	Holy Cross Hospital	Silver Spring	Montgomen	cy
	Funeral Director		5. Social Security Number 581-42-3747 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Bi May 26, 1916 Pe	rthplace (State or Foreign country) ennsylvania
	p.		Usual Residence of Decedent			I dod beside Oite Unite
	arylar show d at	ī	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ANo
	he M.	Director	Maryland Montgomery Silver Sp 10e. Street and Number	ring 10f. Zip Code	10g. Citizen of What C	
	a or	Di	705 East Franklin Avenue	20901	USA	ounity:
	ns 23	Funeral				erican Indian,
36	be filed within 72 hours after death with the Maryland ttal Hyglene. dother than "natural", or Items 23a or 28a-f show event, I'm "hidred Erminer must be notified at	by Fur	1 ☐ Never Married 2 【本Married 1本 Yes 2 ☐ No	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I □Yes 2☎ No Specify:	Specific	
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedenties	dent's Usual Occupation	16b. Kind of Business	
2	hin 7	Completed	(Specify only highest grade completed) (Give life. I	kind of work done during most of work DO NOT use retired)	ring	
7	ed wit	Con	5+	Physician	Medical	
nd	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
<u>yla</u>	ould I Mer narke	ပ္	Chauncey McLean Gilbert		Marguerite Young	
, Maryland	and 2 st ealth and n 27 is n				ral Route Number, City or Town, State, e, Silver Spring,	' '
Baltimore,	Pages 1 ent of Ho nt; If Iten ry or oth		ALIBURAL Z LICTERIATION 3 LI REMOVALITORI STATE I	natory or other place) J	Date une 25 20c. Location - City o	
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Middeal Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22	Name and Address of Facility Francis J. Collin	s Funeral Home Inc	
			23a. Part 1. Inter the disease, or complications that cause the death. Do not ent			Approximate
	Physician		shock, I heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death minutes
1	/Medical		disease or condition resulting in death) ACUTE MYOCATCIAL Due to (or as a consequence of):	Intalccion		minuces
	Examiner		Atherosclerotic C Sequentially list conditions,	ardiovascular Dis	ease	years
	ed sit	Examiner	that initiated events Sequentially is continued at the cause. Enter Underlying Cause (Disease or injury that initiated events C.			
)	ficate be executed physician and s the burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last C			
8760,	be exician buria	a E	But to (or as a consequence of).			
687	ficate phys s the	edical	d			
X	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
P.O. Box	death e atte	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month	Day Year
<u>Ч.</u> О	at the by th tache	hys	9 Unknown			
Ś	es tha		Part II. Other significant conditions contributing to death but not resulting in the un Polymyalgia Rheumatica, Secondary Hy	, , ,	23e. Did tobacco use contribute	
ord	requir	ted	Tolymyalgia Miedmatica, Secondary ny	pochyrotatsm	1 ☐ Yes 2 🖾 No 3 ☐ I	Probably 4 Unknown
3ec	e 2 sh	Completed by			autopsy prior to	autopsy findings available completion of cause of
<u></u>	Physician: The le this certificate ha ral director, page 2	S			performed? death? 1 □Yes 2 □No 1 □ Ye	s 2 🗆 No
Ž.	certif ector	Be	25. Was case referred to medical examiner? Hospital: Ho	Other	th (Check only one)	
of	Phys r this ral dir	<u>۱.</u>	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death	IL 3 DOA 4 Nuising H	ome 5 Residence 6 Other (Sp 28d. Describe how injury occurred	ecify)
on	ding h. Afte fune	tion	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	28c. Injury at Work? M 1 □ Yes 2 □ No	20d. Doddingo flow signly doddinod	
Division of Vital Records,	Atten	Certification: To	3 Suicide 6 Could not be		28f. Location (Street and Number or I	Rural Route Number,
á	al or s afte il Dire	Sert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as	Medical (29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deatter of the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause(s) and manner rred at the time, date and place, and de	as stated. ue to the cause(s)
	o the	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)
	- S F 8		MANTACHMUMITATION	MD012224		
	197		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Marta Schneider, MD 5401 Macarthur	Blvd. NW, Washin	gton, DC 20016	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 22 2009	KI		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:12 AM Robert Eugene Green 200F line /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day Year) | March 15,1956 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Maryland 53 213-68-5848 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mentla Hyglene.

It of Health and Mentla Hyglene.

It is then 27 is amarked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Evanina Fust by notified at 10a. State 1 √2 Yes 2 □ No Director **Hagers**town Washington Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21740 118 Elm St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Co. Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Jane Green UnKnown ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 220 Valley Dr. Fayetteville, Pa. 17222 Angela Shifflette (Daughter, Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any injury or
once. Smithsburg, Md. Smithsburg Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Nege Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed Hepotiti sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Q Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No has page 2 1 ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2⊠No ၉ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl Certification: 27. Manner of Death After 1 Injury 1 🙀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 🗖 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Ontretan St. Hagestown MO 21740 KaMO Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

JUL 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** :45am MARY EVELYN GARLOCK une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Plata Medical Center 9. Birthplace (State or Foreign Country)
WASH , D . C . If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT . 17, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1 □ M 2 🖫 F 577-40-2168 78 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State MD. CHARLES BRYANS ROAD 1 ☐ Yes 2 ☐ Xo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20616 2961 EDGEWOOD ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give⁷ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify.WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry NAVAL RESEARCH LAB Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. SECRETARY 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES BENJAMIN EDWARDS MARY VIOLA WESLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES KELLY GARLOCK-SON 2961 EDGEWOOD RD. BRYANS ROAD, MD. 20616 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 6-30-09ALEX., VA. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee Moo479 23a. Part1. Enter the disease, or complications of shock, or heart failure. List only one can be immediate Cause (Fisc.) Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a co Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

The law requires that the death certificate be executed attending physician and for use as the burial-trar P.O. Box 68760, signed by the at the detached for of Vital Records, page 2 s certificate this completely filled in by the funeral or Attending after death. Hospital within 24 hours a

Funeral

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinar in ust be nutflied at

Pages 1 and 2 should be filed within 72 hours after

of Health a

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Maryland

Baltimore,

State Registrar

Medical

JY

29b. Signature and title of certifier

31. Date filed (Month, Day,

4 Homicide

29a. Certifier

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Center 7-C Post Office Rd

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 30 ay 2009 ear **Physician** 18:05 LUCIUS CARLTON HARPER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 M M 2 □ F 214-14-7701 Director 93 11-01-1915 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show event, the Medical Evaniries must be notified at 1 X Yes 2 □ No Director MD ALLEGANY FROSTBURG 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 2 21532 death v 85 BEALL STREET EXTENDED U.S.A. Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Yes. Give þ Specify: 3 Widowed 4 □ Divorced BLACK natural", Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the any Europe. OWNER/OPERATOR RESTAURANT 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HATTIE AUGUSTUS BOLDEN HARPER WILLIAM LUCIUS HARPER မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE HARPER SON 760 HUNT TERRACE CUMBERLAND, MD 21502 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 07-03-2009 CUMBERLAND, MD 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mruseps 15 **Physician** disease or condition resulting in death) /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 🗌 No 3 ☐ Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 hours after le Funeral Dire pletely filled in b 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

30. Name and address of person

address of person who completed cause of death (item 23a) (Type, Print)
SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

V Bulland

DHMH 17 Rev 1/2001

D33280

2009

		1- State of Maryla State of Maryla		artment of He rtificate of D			giene Reg. No. 🤈 (100	21620
· · · · · · · · · · · · · · · · · · ·	3	Decedent's Name (First, Middle, Last)	-			2. Date of De	ath	1117	3. Time of Death
Physic /Med		David Ralph Kinsley				June	20 20	2009	06:15 AM
Exam				4b. City, Town, or I	Location of Death	1	4c. Coun	ty of Death	
		4a, Facility Name (If not institution, give street and number) Shelter Cove Yacht Basin 230 Riverside Drive		North Ea	ast			Cecil	
Funera Directo	_	209 – 38–3412	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Nov • 2.	th y, Year) 2,1948	Coun	lace (State or Foreign try) sylvania
and w		Usual Residence of Decedent 10a. State 10b. County 10c. 6	City, Town or Lo	cation				1	0d. Inside City Limits
Maryl f sho	ō	Maryland Cecil N	orth Ea	o. tr					1 ☐ Yes 2X No
the 28a-	rect	Maryland Cecil N	OILII Ea	10f, Zip Code			10g. Citizen of	f What Cour	itry?
3a or	0	406 East Cecil Avenue		21901			Unite	d Star	tes
deati	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No	- 14. Ra	ace - Americ	
6 after or ite	Fu	1 Never Married 2 Married 1 XYes 2 No		irres, specily cubar 1 □ Yes 2√00X0No	Specify:	o nicari, etc.)		ack, White,	
21215-0036 / ad within 72 hours after death with the Maryland gliene: er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	dby	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 196	6-69	TE Tes ZESTO	эреспу.		Spec	ny: WIII	
5-C	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done du DO NOT use retired)	tion uring most of work	king	16b. Kind of I	Business/Inc	dustry
121 within	I d	Elementary/Secondary (0-12) College (1-4or 5+)		uck Drive			Denta	1 Fan	ipment
Hygic Hygi Hygic Hygi Hygi Hygi Hygi Hygi Hygi Hygi Hygi	ပို	17. Father's Name (First, Middle, Last)	111		18. Mother's Nam	ne (First, Middle,			rpmene
d be ental	o Be	Walter A. Kinsley			Iris Ho			,	
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	L L	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Rui	ral Route Numb	er, City or Tow	n, State, Zip	Code)
Ma nd 2 alth a 27 is r trau		Vickie L. Kinsley / Spouse	406 E	ast Cecil	Avenue.	North 1	East. M	larv1a:	nd 21901
is 1 a of Hear Item		20a Method of Disposition 20b	Place of Dispo	sition (Name of		Date	20c. Location		
Page Page Tent c		1 X Burial 2 □ Cremation 3 □ Removal from State 1 N Donation 5 □ Other (Specify)	ndianto ational	matory or other place with Gap Cemetery	June 20		Annvill	e,Peni	nsylvania
Baltimore, Maryland 21215-0036 / permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	į	21. Signature of Juneral Service Incenses	22	2. Name and Address	s of Facility Cro	uch Fu	neral H	lome	
M 205 # 6	R	1000000	12	7 South Ma	ain Stre	et, Nor		, Mar	yland 2190
		23a. Par 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not ent	7		or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	-9 (ance	1			- 1	inknown
Examine		Due to (or as a cons	equence of):						
	ē.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):						
uted	m in	cause. Enter Underlying Cause (Disease or injury							
exection and training the state of the state	Examiner	that initiated events resulting in death) Last C. Due to (or as a cons	equence of):						
68760, ifficate be executed g physician and as the burial-transit	dical								
	Medi	IC CEMALE.							
Geath certifies a strending of for use as	an/I	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ F		Ectopic pregnancy				Date of delive	,
	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ Vo 9 □ Unknown		Other (specify)			, n	Month	Day Year
eta de p	Phy	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause give	n in Part I	23a Did t	obacco use co	entribute to the	ne cause of death?
ds, uires ti signe d be d	l by					10		3 □ Prob	
() > 9 m	Completed								
The law ate has bage 2 st	lg m					24a. Was autop perfo		prior to con death?	psy findings available mpletion of cause of
ta &		25. Was case referred to medical			00 Plana (Para	1 Yes	20 No	1 ☐ Yes	No
Or Vita Physician: this certific ral director,	o Be	examiner?	☐ ER/Outpatier	Otho	r: 4 Discussion Li	th (<i>Check only c</i> ome 5 ☐ Resi		Shelt	a cover
	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of			28d. Describe		other (Specification)	
Vision (Attending F r death. ector: After by the funer	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation) Injury		r 'es 2 □ No				-
DIVISION If or Attending after death. I Director: After the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (nber or Rura	al Route Number,
Divine after a Divine after a Divine a	Cer					·			
the Hospital hin 24 hours a the Funeral I	ical	29a. Certifier (Check only (Ch	nowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier		29c. License	number		29d. Date sig	ned (Monthi	Day Year)
To To COD			un	DOR	26/11	10	6	22/	09
		30 Name and address of paragraphs and address of paragraphs	tom 22a) /T	Print)	27640	17	01	-01	
10+IVA	· .	30) Name and address of person who completed cause of death (If	em zsaj (Type,	The L	1 1 2	DO FI	KL.	Mr	21901
		31. Date filed (Month. Day, Year) 32. Registrar's Sig	nature 9	NO 120	اللا الح	Va Cl	MON	1000	101/04

Registrar

JUN 2 3 2009 Sever A. Signature

			for State Registrar	State o	f Marylan	•	artment of rtificate o	Health and f Death		giene Reg. No. 🤈	nno	21630
			Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		Charles Katz						June 19			7:10 p ^M
m day.	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town	, or Location of Deat	h	4c. Cour	nty of Deat	th
and t			6913 Nevis Road				Bethe				tgome	
	Funeral		5. Social Security Number 579-42-2112	6. Sex 12∑ M 2 ☐ F	7. Age (In yrs. 97	last birthday) Yrs.	If Under 1 Year Months Day		(Month, Day	v. Year)	Co	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent		97	7.0			May 10	, 1912	PIC	huania
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Mar a-f sh	ctor	Maryland Montgor	nerv	Bet	hesda						1 ZYes 2 ☐ No
	or 28	Directo	10e. Street and Number		'		10f. Zip Code	•		10g. Citizen	of What Co	ountry?
	23a	ral	6913 Nevis Road					20817				S.A.
	ter m	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. F	Race - Ame Black, White	erican Indian, e, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	ed 1 <u>∏</u> Ye <i>s</i> If Yes, Gi Year or D	ve		1 □Yes 2 N	lo Specify:		Spe	ecify: W	Vhite
9	filed within 72 hours after death with the Maryland Hygiene. The than "natural", or items 23a or 28a-f show ent, the Medical Evandrer must be redified at	ted	15. Decedent'			16a. Dece	dent's Usual Occ	cupation		16b. Kind of	f Business	/industry
215	e. e. an "ne Medi	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work dor DO NOT use reti	ne during most of wor ired)	rking			
21	d with	Completed	12	- Comogo (Butch	er/Owne	r		Superm	arket	
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	a <i>st</i>)					me (First, Middle,			
yla	ould by Men	10	Yossel Katz						"unasce		_	
Nar	12 sh th and 7 is m traum		19a. Informant's Name/Relationsh			1		eet and Number or R		· ·		
e,	1 and Healt em 2		Jay F. Kaufman,	grandsor				d Road, B	Date Date			20817 Town, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If item 27 is marked to the than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be retified at once.		1X Burial 2 ☐ Cremation		State Ga	rden of	sition (Name of matory or other p Rememb 1 Park	rance	2 / 2000		•	
Ħ	nit. P artme ortan Injur e.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fuperal Service L		l r							, Maryland
ñ	Depa Impo any Ir) Carrotan		101255	I I	Edward S 091 Roc	dress of Facility agel Fune kville Pi	ral Dire ke. Rock	ction, ville.	Inc.	land 20852
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		estive I	Heart H	ailure					Onset and Death
	/Medical		resulting in death)	-	(or as a consec							
	Examiner	_	Sequentially list conditions,		emic Car		pathy					
	ted sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec							
_ In	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Examiner	that initiated events resulting in death) Last	0.	nary Art		Lsease					
8760,	e be e	dical E		d								
89	tificat ig phy as the	ledio	-									
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnation		☐ Ectopic pregna	nev		23d.	Date of de	
О. В	deat he att	sicia	in the past 12 months? 1 □Yes 2 □No		nant at time of		Other (specify,				Month	Day Year
<u>P</u> .	at the de	Physician/Med	9 Unknown			ter t at			00- Did 4			- the source of dooth?
Š,	iires tha signed d be det	ρ	Part II. Other significant condition Hypertension	ns contributing to d	eath but not res	suiting in the u	nderlying cause	given in Part I.		obaccousec ∕es 2√∑No	_	o the cause of death? Probably 4 □ Unknown
0.00	w requir been s should	Completed										
3ec	elaw hash	npl	Chronic Renal F	ailure					24a. Was autop		4b. Were a prior to death?	utopsy findings available completion of cause of
a	n: The ficate h r, page		Prostate Cancer						1 □Yes	2 No	1 ☐ Yes	s 2 No
Ξ	Physiclan: The Is this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		1500		245	ath (Check only o			
oţ	Physer this sral di	יי To	27. Manner of Death	28a. Date	Inpatient 2 C	28b. Time o	" O DOX	4 □ Nursing F njury at vork?	Home 5 Resid			ecify)
lon	Attending Physician: r death. ector: After this certific. by the funeral director, p	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Mor	nth, Day, Year)	Injury		√ork? □Yes 2□No				
Division of Vital Records,	Atten	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 28e. Place	e of Injury - At hing, etc. (Speci	ome, farm, str	eet, factory, offic	e	28f. Location (5 City or Tov		ımber or A	lural Route Number,
	tal or rs afte al Dir ed in	Certification: To	Tiomicide	Dulid	ing, etc. (opeci	· <i>y</i>)			City of 100	vii, State)		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical		xaminer: On the I	pasis of examina			e time, date and plac ny opinion, death occ				
	o the	Mec	29b. Signature and title of certifier	anu mar	ner stated.		29c. Lice	ense number		29d. Date sig	gned (Mon	th, Day, Year)
	- SFO		> mand	bru			D469		1	June 2	-	
	1 4		30. Name and address of person v		se of death (Iter	m 23a) (Type,	Print)					
			Dr. Lillian M.				•	d, Suite	100, Ger	mantow	m, MI	D 20874
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Signa	ature	40.0					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** Dolores Ann Kelly 2009 2 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Farhney Keedy Home & Village Boonsboro Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 □ M 2 👿 F 214-34-9606 74 June 23, 1935 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10h County r items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Washington Smithsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21783 U.S.A. 12233 Itnyre Road Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", or the Medical Exercit 1 ☐Yes 2X No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Bank 12 Teller permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other to any Injury or other traumatic event, I'll once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David E. Bachtell Nina M. Huff ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12233 Itnyre Road Smithsburg, Maryland 21783 (Husband) John C. Kelly 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Prospect 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) สน1น Lewistown, Maryland 2009 Church Cemetery 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Approximate Interval Between Onset and Death 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) RATTUR Physician /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed ECTS physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE: cate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 220No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ∐Yes 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate No 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Teath 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one the 29b. Signatur the of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Jefferson

and address of person who completed cause of death (Item 23a) (Type, Print)

22911

09-04958 Gregory Kent Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 6 3 2

•			1- For State Certificate of Registrar Certificate of	Death	Reg. No		4.100
	Physici		Decedent's Name (First, Middle,Last)		Date of Death Month Day		3. Time of Death
Medic	al Exami		Gregory Kent		June 23, 2009		1505 hrs
ed			4a. Facility Name (if not institution, give street and number) 5515 Marlboro Pike #9	4b. City, Town, or Location of Death District Heights		c. County of Death Prince George'	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_ `	//DD/YYYY) 9. Birth Foreign	place (State or
	Director		579-78-5102 1 X M 2 F 52 Yrs Usual Residence of Decedent	Months Days Hours Min	Feb. 15,		
	any	ŀ	10a. State 10b. County 10c. City, Town or Locat	ion			10d. Inside City Limits
	*	<u>_</u>	Marvland Prince George	Forrestville			1 X Yes 2 No
	Aaryla 28a-f I at or	ecto	Maryland Prince George 10e. Street and Number 5515 Marlboro Pike #9	10f. Zip Code	10g. Ci	tizen of What Count	ry?
	ith the Maryland 23a or 28a-f sho	٥		20747		Inited Sta	tes
	Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she is tother traumatic event, the M. Iteal Examiner must be notified at once	Funeral		is Decedent of Hispanic Origin? (Si es, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
	ffer d I", or ner m	by Ft		Yes 2 X No specify:		Specify: Blac	k
	ours a		15. Decedent's Education (Soecify only highest grade completed) 16a. Deceder during m	it's Usual Occupation (Give kind of ost of working life. DO NOT use ret	work done 16b. ired)	Kind of Business/In	dustry
စ္အ	n 72 h nan "n ical E	olete	Elementary/Secondary (0-12) College (1-4 or 5+)		ŕ	0	
Ş	l withi giene. her tl	Completed	12th Post 17. Father's Name (First, Middle, Last)	Office Carrier 18.Mother's Name	e (First, Middle, Maide	Governm n Surname)	ent
21215-0036	d be filed within 72 hours a fental Hygiene. narked other than "natura event, the M. vical Exami	Be C	William Walker		Gladys Ro		
21;	I and 2 should be filed withi Health and Mental Hygiene. Item 27 is marked other th r traumatic event, the Men	일	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or	Rural Route Number,	City or Town, State,	
M	and 2 shou lealth and N tem 27 is n traumatic		Oracid to Robby Hoteler	10103 Prince Place		Largo, Md	
Je.	es l ar of Hee If ite her tr		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or ot	her place)	June		
Baltimore,	Pagiment tant:			rematory 30 Name and Address of Facility	2009	Clinton,	
Bal	permit. Pages 1 and Department of Hee Important: If ite injury or other tr			001 Benning Rd. N			20019
	hysician		23a. Part I. Enter the disease, or com-lications that caused the death. Do not enter t				Approximate Interval Between Onset and
STATE OF THE PERSON NAMED IN	Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Atherosclerotic card</u>	iovascular disea	ise		Death
	Adminici		or condition resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Levents resulting in death.) Last Due to (or as a consequence of):				
	ansit	Exa	d				
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDED 23a,P11,27,per	ME, g893 7/9/09			
3760.	ficate g phys s the b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	etal death 3 Ectopic pregn		3d. Date of delivery Month D	ay Year
Box 68	leath certifi e attending for use as	ician/	past 12 months? 4 Pregnant at time of death 5 0	ther (Specify)			
8 B	the at the at	Physi	1 Yes 2 No 9 Unknown 9 Unknown		02a Did tabasa	o use contribute to t	ho cause of death?
0	that the de med by the detached fo	by P	Part II. Other significant conditions contributing to death but not resulting in the Diabetes mellitus	underlying cause given in Part I.			ably 4 🗹 Unknown
8	law requires the has been signed a 2 should be d		Diabetes mellicus		24a. Was an		opsy findings available
000	law re has be	Completed			autopsy performed	? death?	ompletion of cause of
Re	cian: The certificate ector, page		25, Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 ✓ Yes	2 No
/ital	sician is cert directo	Be.	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor:		dence 6 🗸 Other	Scene
of)	ng Phy After the neral	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of	Injury 28c. Injury at Work?	28d. Describe how i	njury occurred	
<u>io</u>	tendineath.	턃	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined (Specific)	et, factory, office building, etc.	28f. Location (Stree or Town, State)		al Route Number, City
	fospit: 4 hour muners luners		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, an	d due to the cause(s)	and manner as state	d.
	o the lithin 2.	edical	one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred	at the time, date and	place, and due to the	e cause(s)
	T M T S	¥ ¥	29b. Signature and title of certifier	29c. License number		d. Date signed (Mor	th, Day, Year)
			mesc	O.C.M.E.	Jι	ıne 24, 2009	
•			30. Name and address of person who completed cause of death (Item 23a)	Street, Baltimore, MD 2120	11		
		toto			·		
	Pogis	tate	1111 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	backer			

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			Please Type or Print in Blac				•	
			State of Maryland / I - State negistrar AMENDED 06/23/2009 #7 FCH	Department of I D <i>Certificate of</i>			giene Reg. No.2	21622
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
100	Physici /Medic	al	MARGARET COLLINS LAWLESS	Ab Cib. Taura	and position of Dooth	JUNE	18 2009	11:45A M
ji	Examin	er	4a. Facility Name (If not institution, give street and number) $407 \;\; RUSSELL \;\; AVE \bullet$		or Location of Death		4c. County of Deat MONTGOM	
Ī	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2 F 90	rthday) If Under 1 Year Yrs. Months Days		(Month, Da	y, Year Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent			JUNE 10	, 1919	MO
	/arylar f show	ō	10a. State 10b. County 10c. City, Tow MD MONTGOMERY GAIT	rn or Location CHERSBURG				10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	or 28a-	Jirect	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	untry?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, I've Madical Evaminar must be natified at	Funeral Director	407 RUSSELL AVE. 11 Marital Status 12. Was Decedent Ever in U.S.	2087		nacify Vac or No	USA 14. Race - Ame	rican Indian
9	after de or item		1 Never Married 2 Married Armed Forces? 1943-	13. Was Decedent of I If Yes, specify Cub		o Rican, etc.)	74	
21215-0036	hours tural",	ed by	3 ₩idowed 4 Divorced If Yes, Give Year or Dates: 1946	a. Decedent's Usual Occu			Specify: V	
215	hin 72 e. an "na Madic	Completed	(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retire	e during most of wor ed)	king	HEALTH O	·
7	iled wit Hygien ther th	Con	17. Father's Name (First, Middle, Last)	EDICAL TEC	T	ne (First Middle	Maiden Surname)	ARE
land	ild be f fental I rked of tic eve	To Be	ALBERT COLLINS			KENDZ		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Madical Evanched must be notified at once.		19a. Informant's Name/Relationship (Type. Print) KAREN LAWLESS / DAUGHTER	b. Mailing Address (Street	et and Number or Ru	ural Route Numb	er, City or Town, State, 2	Zip Code) RSBURG, MD
re,	is 1 and of Heal item 2	-	20a. Method of Disposition 20b. Place of cemels	of Disposition (Name of ery, crematory or other pla	ace)	Date	20c. Location - City or	
Baltimore,	t. Page tment tant: If		4 Donation 5 Other (Specify) ROSE	HILL CEME	TERÝ 6/	23/09	GRUNDY CE	ENTER, IA
Ba	permi Depar Impor any ir once.		21. Signature of Roperal Service Licensée		FUNERAL		ILLE, MD	20838
			23a. nt 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Land Mark	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ADULT FAILUR		/E			Onset and Death
	Examiner		Due to (or as a consequence CARCINOMATOS		C)			
	ted ssit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of).			1)	
90,	be executed ician and ourial-transit	Examiner	that initiated events c	of):				
	icate be physicia the bur	dica	d					
Box 687	leath certificate attending physi I for use as the k	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of de	livery
Ö Ö	e death the atte	Physician/Medica	in the past 12 months? 1 Yes 2 No 9 Unknown	h 3 ☐ Ectopic pregnan 5 ☐ Other (specify) _			Month	Day Year
Э.	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the I		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause gi	iven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Division of Vital Records,	equires sen sigi ould be	ted by	HYPERTENSION			1 🗆 '	Yes 2⊠No 3□P	robably 4 Unknown
ည်	elawr hasbe je 2sh	Completed	RECENT CEREBROVASCULAR ACCI	DENT		24a. Was autoj		utopsy findings available completion of cause of
ta E	ician; The certificate hi	ø	WITH HEMIPARESIS 25. Was case referred to medical		26. Place of Dea	1 □Yes	2 DrNo 1 □ Yes	3 2 □No
<u>></u>	ys Si	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	dipatient 3 DOA	her: 4 🗆 Nursing H		dence 6 ☐ Other (Spe	ecify)
ono	ding Ph h. After th funeral	tion:		- · · ·	uryat ork? ⊒Yes 2⊡No	28d. Describe	how injury occurred	
VISI	or Attencafter death Director: In by the	Certification: To	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, fabuilding, etc. (Specify)			28f. Location (Street and Number or Ri wn, State)	ural Route Number,
	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge					e etated
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by t	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.					
	To the Company	Ž	29b. Signature and title of certifier		nse number 0 4 1 1 5		JUNE 19,	
	10		30. Name and address of person who completed cause of death (Item 23a)	- area				
KE			H. ROBERT BIRSCHBACH, MD 2		L AVE.,	GAITHE	RSBURG, MI	20877
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	fall				
			THE TO THE MAN AND THE PARTY OF	- 4 6'				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** June 18. 2009 715 P M Suetelle Liss /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🛣 F Yrs. 11/7/1917 **Director** 026-05-5465 91 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Rockville Montgomery 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5909 Bloomingdale Terrace 20852 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked: any injury or other traumatic evonce. Louis Phillips Rebecca Harris ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Meryl Goodman - Daughter 5909 Bloomingdale Terrace Rockville MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 6/21/09 Olney, MD 22. Name and Address of Facility Edward Sage! Funeral Direction Inc 1097 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licenses MOM63 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Hypertensive Heart Disease Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Atrial Fibrillation Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D ð Dementia Completed

Physician /Medical **Examiner**

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28af show

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

and physician within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Be

Certification: To

ical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

	10.00 -						
	24a. Was an	24b.					
	autopsy performed?						
	1 □Yes 2 XNo						
7.	101 1 1						

ru	LODGCC	o use com	indute to the cau	se or death:
	Yes	2 🗌 No	3 ☐ Probably	4 XUnknown

	24a. Was an autopsy performed? 1 ∐Yes 2 X No	24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No		
26. Place of Death (C	Check only one)			
Other: 4X Nursing Home	5 Residence	6 ☐ Other (Specify)		

21
27. Manner of Death
Matural Natural
2 Accident
3 Suicide
4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

Pay, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)	and manner stated.

31. Date filed (Month, I

25. Was case referred to medical

1 Yes 2 No

and manner stated. 29b. Signature and title of certifier Winns

Hospital:

29c. License number D47330

29d. Date signed (Month, Day, Year) June 19, 2009

30 Name and address of person who com Thomas Joseph MD 50 npleted cause of death (Nem 23a) (Type, Print) #207 Rockville MD 20852

State Registrar parked

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 8:20 AM Dewey Louis MOREHEAD lune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1**№**M 2□ F Days 225-52-5263 68 20, May 1941 Wash. D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 906 Lanvale Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 2 white 3 ☐ Widowed 4 ☐ Divorced 1961 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) private Elementary/Secondary (0-12) College (1-4or 5+) contractor mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey Louis Morehead Laura Rossella Cockrill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 906 Lanvale Street, Hagerstown, Maryland 21740 Minnie J. Morehead - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6/26/09 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME Moles Cola 415 E. Wilson Boulevard, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Recurent pneunonic disease or condition resulting in death) Due to (or as a consequence of): CUMPLICATIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence off that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1∏Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year, 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed burial-transi P.O. Box 68760. attending physician for use as the burial sate has been signed by the page 2 should be detached Division of Vital Records, certificate this After t death. the

Funeral

Director

show

28a-f

items 23a

6

"natural"

and Mental Hygiene. is marked other than

rmit. Pages 1 and 2 sl partment of Health an portant: If item 27 is r y injury or other traun

permit. Page: Department o Important: If i any injury or

Physician

/Medical

Examiner

Mental

within 72 hours after death

Maryland 21215-0036

Baltimore,

the Medical Examiner must be notified at

or Attending To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by

(13H 5+

0 Richard KAR JUN 26 2009 31. Date filed (Month State

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address

Medical

med ical OIIII 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38764

5.4

127

29d. Date signed (Month, Day, Year)

21742

125

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 For State Registra Amend#1.PerPhys.PGC6-30-09cr Certificate of Death Decedent's Name (First, Middle, Last) Bernard J. Magill Sr. 2. Date of Death 3. Time of Death Month 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George 6929 Allentown Rd. Camp Springs Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day) Days 1 ☑ M 2 ☐ F 579-26-0482 April 6,1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Maryland Prince George Camp Springs 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 ÜSA 6929 Allentown Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Milton Magill, Sr. Helen Kenney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marguerite V. Magill/Wife 6929 Allentown Rd. Camp Springs, Md. 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Resurrection Cem. 6/24/2009 | Clinton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Approximate Interval Between Onset and Death 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ø ARCINSONS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 3d. Date of delivery Month Year e contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medical Examiner

permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone.

Physician /Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Directo

by Funeral

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran ned by the a detached f cate has been sign page 2 should be his certificate his director, page funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Certification: To Be Completed by Physician/Medical Examiner

that initiated events resulting in death) Last	C	uence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1	I death 3 Ectopic		2
Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacco us
				24a. Was an autopsy performed? 1 □Yes 2 □No
25. Was case referred to medical			26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ D	OA Other: 4 Nursing H	lome 5 Residence 6
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury

1 ☐Yes 2 ☐ No ☐ Other (Specify) occurred investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

24b. Were autopsy findings available prior to completion of cause of death?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manne stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Date filed (Month

JUN 23

cause of death (Item 23a) (Type, Print)

State Registrar

Medical

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Lucille Katherine Muller 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WICOMICO COASTAL HOSPICIZ AT SALISBURY THR LAKE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 11/5/1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**X** F 88 034-14-7123 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Modical Examiner must be notified at Director Berlin MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21811 44 Anchor Way Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 🗶☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: white à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Banking Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Burke James Edward Deady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other transconce 44 Anchor Way Dr., Berlin, MD 21811 Gail Williams / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/22/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BRRAST CARCINDALA Physician MAHANANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to innue district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of): physician the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Box 68760. Ö ۵. Records, Division of Vital

attending | for use as the detached signed by the cate has I page 2 s

Physician/Medical δ Completed Be ို Certification:

the Funeral Director: After this certificate mpletely filled in by the funeral director, pag Physician: ...ospital or Attending Prin 24 hours after death.
The Funeral Direction of Stehres To the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 27. Manner of Death
Natural
Accident

Medical

State Registrar

4 Homicide 29a. Certifier

3 Suicide

1∐ Yes 2 📶 No

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital:

28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

DO05 8410

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Ce Hanny WARY BOX

31. Date filed (Month, Day, Year)

egistrar's Signature

DHMH 17 Rev 1/2001

3A10

ORIGINAL

5 ☐ Other (specify)

Year

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ∏Yes 2X7No

9:20 AM

23e. Did tobacco use contribute to the cause of death?

No 3 Probably 4 Unknown

1 ☐ Yes autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 Pro

1 ☐ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence State (Specify) HOSPICIZ

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Kathryn McIntyre 2009 June 18 1:30 PM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury Wicomico Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2XF 218-16-7043 84 Director 12-30-1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1XYes 2 No Directo MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ハリナハ (ソカー) | 1 | しよか ナタ・saltimore, Maryland 21215-0036 11974 Edgehill Terrace 21853 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify. Specify: Completed by White 3 V Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lewis Sallie Dryden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5493 Nithsdale Drive, Salisbury, MD 21801

of Disposition (Name of Date 20c: Location - City or Town, State Deborah Booth/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory Salisbury, Maryland 4 □ Donation 5 □ Other (Specify) 06/19/2009 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee 3a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line.

Approximate Immediate Cause (Final disease or condition resulting in death) THERYSCLENGTIC **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ysician/Medical Examiner requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of): as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Dav for 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown signed to d be deta

Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the

a by rill	Part II. Other significant conditions	contributing to death but not res	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow			
onnpiere					24a. Was an autopsy performed 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No
o De	25. Was case referred medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)			
ALIOII.	27. Mapher of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	occurred
) er illice	3 Suicide 6 Could not determined		nome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mann one of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.						

29c. License number

614 Easternshore Dr Salisbury MD 21804

29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title of certifier

Mahesha Thimmarayappa MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

		Please	Type or Prin				k. Ensure A	-		egible.		
		For State Registrar	State of Ma	i yianu /	•	rtificate c		Memain	Reg. No.	2000	216	39
								2. Date of Do	eath	Year	3. Time of D	eath
Physicia /Medic		Charles Thomas Utility						June	Pay 18	2009		ДМ
Examin	٠.	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 4b. City, To				Frederic	k		County of Deatl Freder	ick		
Funeral Director	Months Days Hours Min.					ay, Year)	Co.	hplace (State or i untry) D	Foreign			
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	cation					10d. Inside City	Limits
Mary a-f sho	tor	MD FREDER	RICK	F	REDE	RICK					1 Yes 2	!□No
with the	ᅙ	10e. Street and Number 411 GRANT PLA	CE			10f. Zip Coo			10g. Citiz	ven of What Co	untry?	
ified within 72 hours after death with the Maryland Hygiene. Hygiene. When than "natural", or items 23a or 28a-f show ent, If a Predict Examine must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates:			Vas Decedent f Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puel No <i>Specify:</i>	Specify Yes or N to Rican, etc.)		4. Race - Ame Black, White Specify: WH	e, etc.	
n 72 hou "nature	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Ockind of work do	ne during most of wo	orking		nd of Business/		
d withii giene. er than	Jmo.	Elementary/Secondary (0-12)	College (1-4or 5-	+)		MECH			MON	TGOME:	RY COLI	JEGE
uld be file Aental Hy rked othe tic event,	To Be (17. Father's Name (First, Middle, Las LEONARD JEROME		SR.				me (First, Middle LORETTA		,		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, Inc. Modical once.		19a. Informant's Name/Relationship TERESA OFFUTT	(Type. Print) / SPOUSE				PLACE,				Zip Code) 1702	
Pages 1 and the state of the st		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	20b. Place ceme STAU	e of Dispos etery, crem FFER	sition (Name or natory or other CREMA	place) ATORY 6/	Date 23/09		cation - City or DERICK		
srmit. epartr nporta ny Inju		21. Signature of Euneral Service Lice	**	1			Idress of Facility FUNERAL	HOME				
1 20E 29		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused yone cause on each lin	the death. De.	P	.O. BO	X 86, B	ARNESV		MD_	20838 Approximate Interval Betwo	een eath
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a	consequence	ce of):	Acic	2000					
sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b			19000	<u> </u>					
the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 ☐ Fetal de	ath 3	□ Ectopic pregr □ Other <i>(sp</i> ec <i>if</i>			2	23d. Date of del Month	,	ear
uires that the signed by ald be detacted	þ	Fait ii. Other significant conditions continuously to death but not resulting in the underlying cause given in act.						cco use contribute to the cause of death?				
The law rec cate has bee	Completed							24a. Wa aut per 1 □ Yes	opsy formed?	prior to death?	utopsy findings av completion of cau	vailable use of
siclan certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	-+ 0 T FD	/Out==ti==	nt 3 DOA	Other:	eath (Check only			- % .)	
g Phy er this eral d	 -	27. Manner of Death	28a. Date of Inju	ry 28	Bb. Time of Injury	f 28c.	njury at Work?	Home 5 Re			спу)	
Attending r death.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of Inju	ıry - At home		М	1 □ Yes 2 □ No				ural Route Numb	er,
To the Hospital or vailthin 24 hours after To the Funeral Direct completely filled in b		4 Hornicide	building, etc		edge, deatl	h occurred at t	ne time, date and pla		own, State,		s stated.	
ne Hos n 24 h ne Fur pletely	edical	(Check only 2 Medical Exa	aminer; On the basis o and manner sta	f examination	and/or in	vestigation, in	my opinion, death oc	curred at the time	e, date and	place, and due	e to the cause(s)	
To th	Ň	29b. Signature and title of certifier					cense number	J	29d. Dat	e signed (Mont	h, Day, Year)	
4		30. Name and address of person who	- O tomore	eath (Item 23	Ba) (Type,	Print)	RESTRIC	L -				
48		31 Date filed (Month, Day, Year)	10-	ar's Signature	1415	>r. h	RESTRICI	, mr) 2	.1701		
Sta Registr		31. Date filed (Month, Day, Year)	2009 Inn	a. o oignatule	1. 1	ake						

DHMH 17 Rev 1/2001

Registrar

			Please Type or Print in Black Ind State of Maryland / Depar 1 - State Registrar Cert		ental Hygie	ene
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Paula Lynn Pence		2. Date of Death Month 06	Day 29 09 3. Time of Death 1115 A M
	Examin		4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS	4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY
	Funeral Director		5. Social Security Number 217-60-3926 6. Sex 1 □ M 2□ F 54 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 22	9. Birthplace (State or Foreign Country)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local MD. Allegany Westerns			10d. Inside City Limits XIX]Yes 2 □ No
	with the ia or 28a ibe noti	Director		10f. Zip Code 21562		Drited States
136	Id be filed within 72 hours after death with the Maryland lental Hygiene. ked other than "natural", or items 23a or 28a-f show the event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	 as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R □ Yes 2⊠No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 hou giene. r than "natura The Medical E	Completed	1.5. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Had	ont's Usual Occupation Ind of work done during most of working O NOT use retired) Ir Stylist	g	b. Kind of Business/Industry Hair Styling
yland	2 should be filed voil and Mental Hygie is marked other aumatic event, it	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name Vleada	(First, Middle, Ma Katrina	^{iden Surname)} Stamper
Mar	ind 2 sho alth and 27 is ma er traume		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Address (Street and Number or Rural arsh Ave. Westernp		
saitimore,	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any Injury or other traumatic eoc.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	tion (Name of tory or other place) 07/0 Mem Gardens 2009)3/ _{T.≂}	k. Location - City or Town, State aVale, Maryland
pair	permit. Depart Import any Inj once.			Name and Address of Facility Boal Funeral Home		urch St. aport Maryland 21562
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	,		t, Approximate Interval Between Onset and Death
5	ite be executed ysician and te burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
.O. Box 68/	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the I completely filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐ 4 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ras, r	quires that en signed t uld be deta	by	Tartin Still agrinount something contributing to death but not residing in the arc	derlying cause given in Part I.		cco use contribute to the cause of death? 2 ဩNo 3 ☐ Probably 4 ☐ Unknown
Hec	n: The law re ficate has be r, page 2 sho	Completed				24b. Were autopsy findings available prior to completion of cause of death?
OI VII	Physiclan: r this certific ral director, I	Го Ве	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Repatient 2 ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hom		ce 6 ☐ Other (Specify)
o uois	ending Pt ath. or: After th	Certification: To	27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	28c. Injury at Work? M 1 □ Yes 2 □ No	8d. Describe how	injury occurred
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserves.	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	8f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	n 24 hour n 24 hour ne Funer pletely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversal and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
)	To the complete compl	Ž	29b. Signature and title of certifier	29c. License number D42054	290	1. Date signed (Month, Day, Year) Level 29 TH 2009
		10	30. Name and address of person who completed cause of death (Item 23a) (Type, Proposition of the complete of t	TO DRIVE CLOY	benta	LOSIB QM, Ch
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 2009 32. Registrar's Signature	end		·
DHN	/IH 17 Rev 1/20	001	- Parameter of			

DHMH 17 Rev 1/2001

/Medical **Examiner**

> burial-trar and

the

director,

filled in by the funeral

this

/ ffer or Attending

Director:

within 24 hours a To the Funeral L Hospital

attending physician

Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

>

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Mourasion Due to (a) as a consequence of) memi a Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24a. Was an autopsy perform

25. Was case referred to medical examiner? 1 Yes 2 No Hospital:

1 Inpatient 5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 No

29a. Certifier

27. Manuer of Death 1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

My Sup sim MD 29c. License number

29d. Date signed (Month, Day, Year) 09 301

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

301Name and ad ress of person who completed cause of death (Item 23a) (Type, Print ane

32. Registrar's Signature

31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygienery Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, Day **Physician** June 200 gar 0251 AM Lee Ouick Baron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PG Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min **XX** M 2□ F 578-74-9037 03/06/1953 Washington, DC 56 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location show event, the Medical Examiner must be notified at 1 XYes 2 No Washington Director C with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20010 1456 Oak Street, N.W. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, the Medical Examina. 1 ∐Yes 2 TaNo If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify. ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Private 3 veers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Lewis David Quick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1456 Oak Street, N.W.; Washington, D.C. Linda Ouick Cameron - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 06/23/2009 Beltsville, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee Glendafresman 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ STAGE 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform No No 1 ☐ Yes director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated To the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and tit

State Registrar

Who completed cause of death (Item 23a) (Tyge, Print)

MANAN 7501 SULUA775 ROAD 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6 2Day 2009 4:50 P M **Physician** George E. Reid, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year, 11/26/1941 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days Hours Months 1 **⅓**M 2 □ F Washington, DC 67 218-38-6744 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 USA 8674 Bali Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces 1 ☐Yes 2 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 200No Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Roofer is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ceceil Varnes George E. Reid, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 27 <u> Velna Niederhauser - Reid</u> 8674 Bali Rd., Ellicott City, MD 21043 injury or other Department of Heal 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Gremation 3 Removal from State Ft. Lincoln Cemetery 6/24/2009 Brentwood, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years disease or condition resulting in death) /Medical Due to (or as a insequence of) Examiner Sequentially list conditions, Examiner Climity for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events ospital or Attending Physician: The law requires that the death certificate be executed hours after death. physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) 68760. Physician/Medical attending p for use as t Box (IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) O 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🙀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{Normal Specify} \) 1 Yes 2°No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending in 24 hours after co., the Funeral Director; After the funeral in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| A certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50303 2009 Dad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST DONSON MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month)

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Veat 07:55PM **Physician** JUNE 2009 Ralph Edward Snyder /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours 217-28-1042 Director Nov. 6,1931 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 329 Valley Rd. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Truck Mfg. Ith and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John J. Snyder Helen Viola Rudisill Snyder ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health a Important: if item 27 is any injury or other trau Carlene E. Snyder-wife 329 Valley Rd. <u>Hagerstown, Md 21740</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 6-29-2009 4 ☐ Donation 5 ☐ Other (Specify) | Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 /23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ESPIRATORY MILLURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KULMONURY 1 YEAR OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HEART the Hospital or Attending Physician: The law requires that the death certificate be executed ITHROSCLEROTIC attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by KENAL LNSUFFICIENCY 1 PYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 12 Ho 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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31. Date filed (Month, Day, Year) JUN 2 6 2009

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30. Name and addr ss person no complete

32. Registrar's Signature

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acause of death (Item 23a) (Type, Print)

Registrar

SINAI HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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).	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. County of Death				
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	Funeral		Social Security Number 6. S	FMM 2□ F	V	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Da	h y, Year)		place (State of		
1	Director		578-68-7443	59	115.			3/8/19	50	Wash	ington,	, DC	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	, Town or Lo	ocation					10d. Inside Cit	ty Limits	
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	Jeath Tra 23	Funeral	3321 Clay Place N	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H				4. Race - Amer	ncan Indian,		
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21215-0036	i within 72 hours after death with the Marylan lien. then "naturel", or itema 23a or 28e-f show the Midded Examiner man be nutilised at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation during most of w	orking	16b. Kin	d of Business/l	ndustry		
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Maryland	C1 C0 == =		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street							
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Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or ot once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other pla	1					_	
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	/Medical Examiner		1	Due to (or as a conseq									
极差		7	Sequentially list conditions,	b. END STAGE R Due to (or as a conseq		ISEASE							
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	To the Hospitel or At within 24 hours after or To the Funerel Dirac completely filled in by	edical	(Check only 2 Medical Examone)	miner: On the basis of examina and manner stated.	ition and/or in	nvestigation, in my	opinion, death oc	curred at the time,	date and	place, and due	to the cause(s	5}	
	To the To the comp	W	29b. Signature and title of certifier			~	se number			signed (Monti			
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7			30. Name and address of person sho	completed cause of death (Iter	п 23а) (Туре								
_				01 Hospital Dr	ive Ch	everly, 1	Maryland	20785					
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Year Month 14, 0950 AM **Physician** June Catherine Arlene Stancil /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 02/21/1949 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 □ Washington, D.C 60 Director 577-66-2430 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Microcal Experience must be multiled at 1X Yes 2 □ No Mitchelleville Director P.G. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20721 Funeral 11411 Lake Arbor Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 XNo If Yes, Give Specify Black 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lusher Frierson Walter Grant Jr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4705 Medora Drive; Suitland, Md. 20746 Andre Stancil -Son permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/19/2009 Lincoln Metorial Cell. Suitland, Md. Freeman Funeral Services 22. Name and Address of Facility 21. Signaty neral Service Licensee 4594 Beech Rd.; Temple Hills, Md. 20748 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. r the disease, or complic eart failure. List only on Approximate Interval Between 23a. Part 1 shock. Immediate Carrie (Final disease or condition Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2₽No 1 ☐ Yes 2 □ No 1 ☐ Yes this certific at director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA DICE. 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. reral Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nm Colu 595 107

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

JUN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 12:50A M June 19 Geneva Simms /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Southern Maryland Hospital Clinton Birthpic Country) VA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months 1 □ M 2 🕱 F 87 Sept. 18, 1921 578-24-5886 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
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1411 Southern Avenue #203 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

100 Date (6/26/ Dana Simms/son timore, 20c. Location - City or Town, State 20a. Method of Disposition 6/26/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Pages Department o Important: If any Injury or once. Heritage Memorial 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Waldorf, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses Bai 3910 Silver Hill Rd., Suitland, Md. 20746 23a. P. VI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final well **Physician** estova discusse or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe the Hospital or Attending Physician: The 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 12 No Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□ Yes 2 1 No 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of this After th funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 Clinton, UD. 207 Surratts 31. Date filed (Month, Day, Year. 32. Registrar's Signature State JUN 2 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19 SIMEONE 2009 9:15 A™ CARMELA June /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville St. Joseph's Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Months 2/16/1907 Director 197-12-2195 102 Italy Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show i r 28a-f show notified at 1 □Yes Z □No MD Catonsville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be 1222 Tugwell Drive 21228 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Maryland 21215-0036 Specify: 2 3 Widowed 4 □ Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 4 Homemaker own home permit. Pages 1 and 2 should be filed of partiment of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Negro Pasquale Episcopo 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Maiden Choice Ln. Apt. 1111 Catonsville, MD 21228 Marie S. Kibby Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition IX Burrial 2 ☐ Cremation 3 □Removal from State 6/23/09 4 Donation 5 Dother (Specify) Cathedral Cemetery Wilmington, DE 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Furrial de roice Licensee M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death atheropelestic Immediate Cause (Final Cardrovasula years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for P.O. ☐Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 | Yes 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 | Homicide 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

th. Day, Year) JUN 2 3 2009 31. Date filed (Month

29b. Signature and title of certifier

001 32. Registrar's Signature CAMPERIA

©0. Name and address of person who completed cause of death/()tem 23a) (√ype, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 8 per Fin delible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** P M30 2009 5:00 DORIS ELIZABETH STULL JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1922

Months Days Hours Min. May 25, 2009 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 87 Marvland Yrs. 212-24-3748 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Is marked other than "natural", or items 23a or 28a-f shor aumatic event, Inc. Podical Examinar must be notified at 1 ☐ Yes 2√ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9006 Hamburg Road 21702 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status hours after 1 ☐ Yes 2 ☐ X O If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Animal Care Taker Cancer Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Douglas Samuel Castle Margaret Lambert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 Hamburg Road, Frederick, MD 21702 Mrs. Patty S. Kline, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery July 3, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneval Service Licensee ²²Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only pine cause on each line. Immediate Cause (Final LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Error Unity of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): P.O. Box 68760. the attending physician certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
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To the Funeral Director. After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Learp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parks

Austin Pearre, M.D., 300 West Ninth Street, Frederick, MD 21701

32. Registrar's Signature

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29c. License number

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Externity or must be rediffed at		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	ng Address (Street	and Number or Rui	al Route Numb	er, City or Town	, State, Zij	Code)			
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r Atte ter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Ini building, e	jury - At ho tc. (Specify	me, farm, str	eet, factory, office			(Street and own, State)		ral Route Number,		
urs aff													
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 certifying F (Check only 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner st	of examinat	wiedge, deat tion and/or in	n occurred at the t vestigation, in my	opinion, death occu	e, and due to tr irred at the time	e, date and	place, and due	to the cause(s)		
ro the vithin ro the	Med	29b. Signature and title of certifier				29c. Licens	se number	-	29d. Date	e signed (Mont	n, Day, Year)		
		100	10))	1		D	64395	5	TH	NE 19,	2009		
(10)02		30. Name and address of person wh	1	death (Item	23a) (Type,	Print)			7 000	4.	2009 MEMO 2120		
9		DANIEW BOB	TWWW M 32. Degisti	0 4	0565	NOHA	ALLES ST	. 8417	t 209	DALTIM	ME, MD 2120	4	
Sta Registr	te ar	31. Date filed (Month, Day, Year)	2009	rais signat	d.	arkel							

	, •		Plea _ For	a se Type or Pri Amend Ite State of M	nt in B m 3 p aryland					L Copie s Tental Hy	s Are L ygiene	egible.		
•		_	For State Registrar			Cer	rtificate o	f Deat	h		Reg. No.	2009	21653	
	Physicia /Medic		1. Decedent's Name (First, Midd MARY ELL)	fle, Last) EN WOLFORD						2. Date of D Month June	26, Day 2	009 ^{Year}	3. Time of Death 19:45р м	
	Examin		4a. Facility Name (If not institution Upper Chesapea)				4b. City, Town Bel A	ir				County of Death Harfo		
	Funeral Director		5. Social Security Number 215–20–6908	6. Sex 7. Ag	ge (In yrs. la 81	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Day		der 24 Hrs. s Min.	8. Date of B (Month, E 8/24/1	irth Day, Yea <i>r)</i> 1927	9. Birth Cou Mary	place (State or Foreign ntry) land	
	show	J.	Usual Residence of Decedent 10a. State 10b. County MD Harfe	,	10c. City,	Town or Loc			-				10d. Inside City Limits 1 □ Yes 2X No	
	ith the Ma or 28a-f	Directo	10e. Street and Number		7		10f. Zip Code	1009			10g. Citize	en of What Cou USA		
ಗ್ರಿ ಸ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fredicel Eventine rough be multipled anonce.	/ Funeral Director	20 Box Hill So 11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Decedent Armed Forces' rried 1 1 Yes 2 X	Ever in U.S	S. 13. V	Was Decedent of Yes, specify Co	f Hispanic uban, Mexi		ecify Yes or N Rican, etc.)				
1945 5-0036	72 hours natural", dical Exp	eted by	3 Widowed 4 Privorce	d Year or Dates: nt's Education est grade completed)		16a. Deced	dent's Usual Occ kind of work dor DO NOT use ret	upation		ing		d of Business/Ir		
2121	ed within ygjene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Reta	il Cler	k —			.l	ail Sto	ore	
Jand /	uld be file Mental H arked oth	To Be	17. Father's Name (First, Middle Owen Swann	, Last)						ine Fly		Gurname)		
Mary	nd 2 sho alth and I 27 is ma er traums		19a. Informant's Name/Relation Kelly Geigelm		hter	1	ng Address (Stre Hillcr					Town, State, Zi 1D 2100		
Sultimore, Maryland	Pages 1 a ent of He nt; If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (20b. Pli ce Evai	ace of Dispo- emetery, cren ns Eag	sition (Name of natory or other p le Crem	atory	1	Date /2009		ation - City or T	own, State	
Ook)	permit. F Departm Importar any injui		21. Signature of Furneral/Service	-							., 600) Main,	beita, PA	
	Physician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	complications that cause t only one cause on each l a.	ed the death line.								Approximate Interval Between Onset and Death	
5 68760,	be executed ician and purial-transi	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as d	auds a consequ	ce of):	aet	ly	eeh	m				
MODD/34/293 cords, P.O. Box 6	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 14 40 9 Unknown	23c. If yes, outcome 1	2 Fetal at time of de	death 3	Ectopic pregna Other (specify,				23	3d. Date of deliv	very Day Year	
1000) ords, P	w requires that been signed b should be deta	by	Part II. Other significant condit	tions contributing to death	but not resu	Iting in the ur	nderlying cause	given in Pa	ırt I.		I tobacco us]Yes 2€		the cause of death?	
~ a	Physician: The law rethis certificate has be al director, page 2 sho	Completed	1			($\overline{}$			per	is an opsy formed? 2 4No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No	
Eller Vital	slcian certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:				Ther:		h (Check only				
Du of	ding Phys h. After this funeral di	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date of Inj	jury	ER/Outpatier 28b. Time of Injury	28c. Ir	4 ⊔ njury at /ork? □Yes 2		ome 5 ∐ Re 28d. Describe		Other (Spec	ify)	
Molford, Mary Division of	or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 Could	mined 286. Place of In	njury - At hor etc. <i>(Specify</i>	me, farm, str	eet, factory, offic			28f. Location City or T	(Street and own, State)	Number or Ru	ral Route Number,	
je Je Je	To the Hospital or Attend within 24 hours after deatt To the Funeral Director; completely filled in by the	Medical Ce		ing Physician: To the bes	of examinat									
N A	To the within 2 To the comple	Med	29b. Signature and title of certifi	and manner s	nateu.)		ense numbe			29d. Date	signed (Month	, Day, Year)	
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	Sta	te	31. Date filed (Month, Day, Year	r) 32. Red st	trar's Signat	ure	,			,				

DHMH 17 Rev 1/2001

Registrar

JUL 07 2009

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ORIGINAL

			For State	State of	Marylan		artment rtificate			nd Me	ental Hyg	0.0	000	OICEL
	1200		Registrar 1. Decedent's Name (First, Middle, La	ect)		Cei	inicate	OI L	- Calli		2. Date of Deat	g. No.		3. Time of Death
	Physici /Medic		· ·		WILKINS	SON					Month JUNE	Day 19	Year 2009	12:30P M
4	Examin		4a. Facility Name (If not institution, give	e street and num	ber)		, ,		Location of			4c. County of Death		
1			7000 Brink Ro					_	nsvil					omery
	Funeral Director		5. Social Security Number 6. S 305-40-1028	Sex 1 X M 2 □ F	7. Age (<i>In yrs</i> . 70		If Under Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Sept. 23	Year) , 1938	9. Birthp Cour Ca	place (State or Foreign ntry) lifornia
	P.		Usual Residence of Decedent		1.0 0									
	trylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits 1 Yes 2 No
	e Ma Ba-f s tiffier	cto	Md. Montgo	mery		Layt	onsvi							
	or 2	Dire	-10e. Street and Number				10f. Zip	Code		_	1	Og. Citizen of		,
	ath w	ra l	7000 Brink Road	T		0 10		4 - 5 1 12	2088				ed St	
	er de items	nue	11. Marital Status	12. Was Dece	ces?	.S. 13.	was Deced If Yes, spec	fy Cuba	spanic Orig n, Mexican,	, Puerto R	cify Yes or No- tican, etc.)		ack, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with figury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes If Yes, Give Year or Da	9		1□Yes 2	⊠ No	Specify:			Spec	ify: Wh	ite
5-0	72 hc natul	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	Occupa	ation Turing most	of working	a i	16b. Kind of	Business/In	dustry
2	ithin ne. nan "	n de	Elementary/Secondary (0-12)	College (1-	4or 5+)							_		
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pu	be fill d off	Be	17. Father's Name (First, Middle, Las							rs Name (lilee)	(First, Middle, M	naiden Surna mker	ame)	
yla	ould Mer narke	၉		lkinson		T								
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "'traumatic event, the Mec	3	19a. Informant's Name/Relationship Christine Wilkin		ife		0				Route Number			0 Code) 1882
	1 and Health em 27	1	20a. Method of Disposition	7 113		Place of Dispo			1	Da		20c. Location		
Baltimore,	Pages nent of H int: If ite iry or of		1 ☐ Burial 2 🗹 Cremation 3 [State	cemetery, cre etropol	matory or ot	her place	' i		0/09		•	a, Va.
ij	urtme artme ortani Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Me		2 Name and	I Addres	e of Facility	,	·		andri	.a, va.
Ba	A Donation 5 Other (Specify) Metropolitan Crem. 6/20/09 Alexandre									Md.	20882			
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca one cause on ea	used the deal ach line.	th. Do not ent	ter the mode	of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	a I	BRAIN C	CANCER								JAN . 08
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):											
48	LAGITITICI	Į.	Sequentially list conditions,	b	or as a consec	allongo of):								
	ted rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence or,								
	icate be executed physician and s the burial-transit	xar	that initiated events resulting in death) Last	CDue to (or as a consec	quence of):	-							
8760,	siciar buri	dical E		d										
687	ficate phy: s the	edic	3.50	u										
Box	nding use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			7					23d. E	ate of deliv	ery
	requires that the death certificen signed by the attending I hould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna	irth 2□Feta antattime of o		∐Ectopic pre ☐ Other <i>(sp</i> e					0	Month	Day Year
P.0	it the by the tache	hys	9 🗆 Unknown	9□Unkno	wn						T			
	ss tha gned se de		Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying ca	use give	en in Part I.					the cause of death?
Records,	w requires t s been signe should be o	Completed by									1 □ Ye	es 2∏ No	3□ Pro	bably 4 🗖 Unknown
ec c	law as b	plet									24a. Was a		. Were aut	opsy findings available ompletion of cause of
	The law ate has b	E O									perform	ned?	death?	
ita	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
7	Physician: r this certific ral director,	ToE	1 Yes 2 No	Hospital: 1 🔲 li	npatient 2] ER/Outpatie	nt 3 DO	A Othe	er: 4□ Nur	rsing Hom	ne 5 Reside	ence 6 🗆 O	ther (Speci	fy)
0 4	ding Pt n. After th funeral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time o Injury	of 28	Bc. Injury Work	at (?	2	8d. Describe ho	w injury occ	urred	
Sio	Attending r death. ector: After by the funer	atic	2 Accident investigation				М	1 🗆 🕆	Yes 2□N	No				
Division or Vital	d or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place	of injury - At h ng, etc. <i>(Sp</i> ec <i>i</i>		reet, factory	office		2	8f. Location (St City or Town		nber or Rur	al Route Number,
	oital (urs af eral D		On Ontifier A Page 114 -	hustal == 7° ···	hant of a con-	and a decident	da ======	A A1 **		d m1 = -				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the miner: On the ba and mann	asis of examina									
	To the within 2	Me	29b. Signature and title of cerlifier		1) .	29c	License	e number		2	9d. Date sigr	ned (Month	, Day, Year)
			1 14 4 3	when the	0	w	7	D05	809			June	19, 2	2009
	LB -		30. Name and address of person who	completed cause										
	20		John G. Lodmell	M.D.	2901	lney-S		Spri	ng Ro	oad,	Olney,	Md.	20832	2
	Sta	ite	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature	11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 06 0^{Yea} 25^{Day} **Physician** 1012 AM Drema Lynn Warnick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany WMHS Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day) **Funeral** Months Country Maryland Days Hours Min. 1 □ M 2 F 214-80-4439 52 June 13, 1957 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Adical Event in the residual to residual. 1 ☐ Yes 2 No Director Lonaconing Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21539 15514 Old Coney Cemetery Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1□Yes 2XNo Specify: þ Specify. White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Lee Airhart James Warnick ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15514 Old Coney Cemetery Road, Lonaconing, Maryland, 21539 Virginia Warnick - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date June 29. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moscow Mills, Maryland Laurel Hill Cemetery 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 8 East Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus non each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hor Ya neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 Z No 24a. Was an this certificate has autopsy performed? 1 Yes 2. No Physiclan: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number June 26, 200 9 200 33280

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 9 2009

K. Sunic Gupta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DK. SUNIC GUPTA 625 KENT AVENUE CUMBERLAND, MD 21502 625 Kent 32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed

		Please Type or Print State of Mar		ndelible lnk. partment of H		-	_	ole.		
		1 - State Registrar		ertificate of L		Re	g. No. 2	109	21655	
Physic /Med		1. Decedent's Name (First, Middle, Last) Janice Cecelia Wolfensberg	er			2. Date of Death Month	Day	Year 809	3. Time of Death	
Exami		4a. Facility Name (If not institution, give street and number) Washington County Hospital		Hagerst			4c. County of Death Washington			
Funeral Director		5. Social Security Number 6. Sex 1 M 2 7 Visual Residence of Decedent	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		lace (State or Foreign try)		
Maryland f show	jo	10a. State 10b. County	10c. City, Town or L					1	0d. Inside City Limits 1 Xes 2 ☐ No	
with the I 3a or 28a	I Director	Maryland Washington 10e. Street and Number 1304 Pennsylvania Ave.	Hagers	10f. Zip Code 2174	2		g. Citizen of W	try?		
paritimities, invary facing ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Mcclent Evantrian must be notified at annes.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No				ean Indian, etc.		
thin 72 hours aft the "natural", or Medical Every	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done of DO NOT use retired	during most of workir		6b. Kind of Bu			
drid 21	Be	17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name					
all yic should and Mer s marke umatic	은	Albert L. Poffenberger 19a. Informant's Name/Relationship (Type. Print)	Mildred and Number or Rura	V. Bet		State, Zip	Code)			
C, Mal 1 and 2 sh Health and em 27 Is n ther traun		Lisa M. McAfee / Daughter		27 Shankto			arylane			
dillinory mit, Pages partment of portant: If ite y injury or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal are of Funeral Service Licensee	Smithsbu	position (Name of ematory or other place rg Ctremat 22. Name and Addre	ory 6/26/	′2009 Si	mithsbu	ırg,	Maryland	
permi Depar Impo any ir		I the hit sum	_	1601 Penns	sylvania <i>A</i>	ve. Hag	erstown		ryland 2174	
Physician /Medical		resulting in death)	consequence of):	inter the mode of dyir	ng, such as cardiac c	or respiratory arre			Interval Between Onset and Death	
Examiner		Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	MS(Mo	1) is ease					104	
fou, te be execute ystcian and te burial-trans	cal Examiner									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown			te of deliver	ery Day Year				
quires that in signed by	by P	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause giv	en in Part I.		acco use cont s 2 □ No		he cause of death?	
The law requires t cate has been signe page 2 should be or	Completed					24a. Was ar autops perform 1 🗆 Yes 2	y ned2/	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2 □No	
ysician: Tysician: Tis certificat	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Japatien	nt 2 🗆 ER/Outpat	ient 3 □ DOA Oth	26. Place of Deather: 4 ☐ Nursing Ho	me 5 ☐ Reside		er <i>(Speci</i>	fy)	
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uital or Att urs after de ral Directe		4 ☐ Homicide determined building, etc.	(Specify)	street, factory, office		City or Town	, State)		al Route Number,	
thin 24 hou thin 24 hou the Fune	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner state 29b. Signature and title of certifier	examination and/or		opinion, death occur	red at the time, da		and due t	o the cause(s)	
1 1 1 1 1 1 1 1 1 1		1 32	ath /Itom 32a\ /T	05.	2323		_		-2009 Stown, MD21	
34-0		30. Name and address of person who completed cause of de	Seem	MD 1	126 OPA	c/ Can	RI H	wes.	stown, rips	
Si Regis	tate trar	JUN 2 6 2009	N. A.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month June **Physician** 19 1:25 A^{M} THOMAS Ν. WOODSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S SUITLAND 2103 LAKEWOOD STREET 8. Date of Birth (Month, Day, Year) 01-28-1923 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Min. 1 € M 2 🗆 F Days Hours 297-16-5683 86 Ward, WV **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm "had a traumatic event, I'm "had 1X∑XYes 2 □ No Director Prince George's Suitland Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20746 2103 Lakewood Street USA e filed within 72 hours after death all Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Government Cartographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fil iment of Health and Mental H tant; If item 27 is marked otl Margaret A. Coleman Thomas H. Woodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Lakewood Street Suitland, MD 20746 Henrietta L. Woodson/wife other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-26-2009 Cheltenham, Maryland Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11/0/37 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Hedgman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Brain Tumor /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death signed by the aid be detached for Division of Vital Records, P.O. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Completed Elevated cholesterol 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t al or Attending Patter death.
I Director: After de in by the funers 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

CR 5

31. Date filed (Month, Day, Year)

JUN 2 3 2009

Lawrence Zimnoch,

30. Name and address of person who conveted cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Registrar

16729DC

23111 M Street, N.W. #302 Wash., DC 20037

June 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Wal yland / State Registrar		tificate of L			Reg. Na.	009	216	58	
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> F rancenia Ella Whitfield				2. Date of Dea Month June	ath Pay	,200 9ear	3. Time of D	eath A M	
	/Medio		4a. Facility Name (If not institution, give street and number) 13004 Crocker Place			Location of Death		4c. 0	County of Death			
anger"	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last bi		Upper Mar If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	th ly_ Year)	P.G.	place (State or a	Foreign	
	Director		24256-6150	Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Day Hours Min. Month Day Year Country Country Charlotte, N. C.							
	aryland show	5	10a. State 10b. County 10c. City, Tow MD. P.G.						1	0d. Inside City 1x☐Yes 2		
	r 28a-f	Director	MD. P.G. Upper	. Mari	10f. Zip Code			_	en of What Cou	ntry?		
	s 23a o	eral D	13004 Crocker Place	10.11	20774	and Original (Se	asit. Van as No	U.S	4. Race - Ameri	nan Indian		
036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, I'm M. diral Eviminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba □Yes 2 XX No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.		
21215-0036	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation Juring most of work	ing	16b. Kin	d of Business/In	dustry		
212	filed within 72 Hygiene. other than "nai ent, In Moli	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Mesters	Tead		,		P.G. County School				
and	uld be filed Aental Hygi rked other tic event, I	Be	17. Father's Name (First, Middle, Last) Roosevelt Johnson			18. Mother's Nam			Gurname)			
	12 should be the and Mental 7 is marked of traumatic even	7	19a. Informant's Name/Relationship (Type. Print)		g Address (Street a					Code)		
	1 and Healt em 2 ther		20a Method of Disposition 20b, Place of	of Dispos	Crocker Pla	1	Marlboro Date		20774 ation - City or To	own, State		
Baltimore,	Pages nent of ant: If its ary or o		cemete	ery, crem	s Cenetery	06/22	/2009		enham,Md.			
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Cervice Lice Lee	NIII.	. Name and Addres		4594 Bee	ech Rd.		20748 Hills,Md	0	
	t.		23a. Parti. Inter the disease, or colon attorns that caused the death. Do shook, or heart failure. List on on cause on each line.	not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Betwo Onset and De	een eath	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence		struct	TVE FUIN	nonary .	Disc	ase .	10 year	<u>es</u>	
	Examiner	<u></u>	Sequentially list conditions, b.	, , , f),								
	cuted of ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Flury that initiated events)	9 01):					4			
60,	ficate be executed I physician and s the burial-transit	al Exa	that initiated events resulting in death) Last C Due to (or as a consequence	e of):								
68760,	± 5, 6	Medical	d		-							
. Box	attendi for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)	<i>y</i>		2	3d. Date of deliv	•	ear	
J .	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to t	he cause of de	ath?	
ords	require een sig nould bi	ted b	Failed Back Syndrome				1 🗆 '	Yes 2.₽	No 3□ Pro	bably 4 ☐ Ur	ıknown	
Rec	The la ate has page 2	Completed					24a. Was autor perfo 1 □ Yes	psy rmed?	prior to co death?	opsy findings avompletion of car		
Z	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatien	t 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H			Other (Speci	fy)		
0 0	iding Phys th. After this of funeral directions	tion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Time of Injury	Work	yat t? Yes 2 □ No	28d. Describe	how injury	occurred			
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)			28f. Location (City or To		l Number or Rur	al Route Numb	er,		
	Hospit 24 hours Funera stely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge and manner stated.	ge, death and/or inv	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)		
	To the Hos within 24 ho To the Fun completely	Mec	29b. Signature and title of certifier 29c. License number D 50343 June 15, 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelvin B. Hao MD 14999 Heath Center Drive # 201 Bawie, Maryland 2									
	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type !	Print)	9343		Jur	e 10, 1	2009		
1	Lid		Kelvin B. Hao MD 14999 Heath	(en	ter Driv	x #201	Bown	e, M	aryland	20716		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Synature 33. Registrar's Synature	フ								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} 2009 JUNE 17, 2:00 LEMUAL JUNIE WALKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 6618 Greenvale Parkway Riverdale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 XM 2 ☐ F Eagle Rock, NC 10/15/1952 56 244-88-9665 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 ☐ No Director Maryland Prince George's Forestville 10g. Citizen of What Country? 10e. Street and Number 20747 United States 6700 Darkwood Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Automotive Technician 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Grisson ဥ Ralph Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6700 Darkwood Ct. Forestville, Maryland 20747 <u>Eunice C. Walker / Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remoyal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 6/24/2009 21. Signature of Funeral Service Licens 22. Name and Address of FacilityPope Funeral Homes, P.A. 23a. Part Y. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCER UNKNOWN PRIMARY SITE Due to (or as a consequence of): Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bue to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify Daughter Home Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

that the death certificate be executed Box 68760. P.0. Records, **Division of Vital**

attending physician for use as the buria been signed by the should be detached has page 2 certificate Hospital or Attending Physician; death. n 24 hours after death.

The Funeral Director: A pletely filled in by the the within To the

Funeral

Director

show

d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

Il Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic event once.

Physician /Medical

Examiner

burial-trar

Baltimore.

filed within 72 hours after death with the Maryland

State Registrar

Medical

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D- 64153

June 22, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

5926 Woodyard Road Clinton, MD 20735

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 Momicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kerry Donald Wall	1	- For State Registrar	State of Marylar		artment o tificate o		and Ment		Reg. N	40. 200	9 21661
Physician Medical Examine	1	1. Decedent's Name (First, Min Kerry Dona						2. Date of Month June 2	Death Da 3, 200	y Year	3. Time of Death 1702 hrs
	ľ	4a. Facility Name (if not institu		ber)		4b. City, Towr	, or Location o			4c. County of Death Washington	<u> </u>
Funeral	4	5. Social Security Number		. Age (In yrs. la	ast birthday)	If Under 1	Year If Under		of Birth(M	M/DD/YYYY) 9 Bir	thplace (State or on Maryland
Director		217-74-5856	1 M 2 F	48	Yrs		Days Hours	Min. Mar	ch 2		untry)
any	-	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City,	Town or Locat	tion					10d. Inside City Limits
Maryland 28a-f show datonce	5	Maryland Wa	shington	Sn	ithsbu	rg 10f. Zip Coo	10		100.6	Citizen of What Cou	1 Yes 2 X No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	3	21833 Jeffer	son Blvd.			2178:				SA	
er death with t	ē	11. Marital Status 1 Never Married 2	12. Was Deced	ces?				in? (Specify Yes o Puerto Rican, etc.		14. Race - Amer White, etc.	ican Indian, Black,
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Midd Frederick W						s Name (First, Mid e Elizab		· ·	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene Importment of Health and Mental Hygiene. Importment: If tiem 27 is marked offer than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Europeal Director	2	19a. Informant's Name/Relation Eric Walker/S								City or Town, State Texas 77	
re, M 1 and 2 F Health Fitem 2 or traur	ŀ	20a. Method of Disposition 1 X Burial 2 Cremat	ion 3 Removal from	l .	Place of Dispos crematory or ot		f cemetery,	Date	20	c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite			Specify:	Par	klawn 1			July 1, 2009			, Maryland
Bal permi Depar Impo injur		Solo	J 5 are	200						Home Inc ilver Spr	ing, MD 2090
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box 68760, the death certificate be execut the death certificate be execut by the attending physician and ched for use as the burial - tra	201	IF FEMALE: 3b. Was decedent pregnant in	23c. If yes, ou					AU T		23d. Date of deliver	
Box 6876 death certificat the attending ph ad for use as the	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	past 12 months?	4 Pregnar	nt at time of de	ath -	etal death ther (Specify)	3Ectopic	pregnancy		Month I	Day Year
that the death		Part II. Other significant cond	Jnknown g Unknow	_	esulting in the u	underlying cau	se given in Par	t I. 23e. [Did tobac	co use contribute to	the cause of death?
Division of Vital Records, P.O. had or attending Physician: The law requires that the starte death. al Director: After this certificate has been signed by led in by the funeral circtor, page 2, should be detach artification: To Re Commisted by D.				<u></u>					Yes 2		bably 4 Unknown
Records, The law requires ficate has been sig., page 2 should be							. <u>-</u> -	— <u> </u>	Vas an autopsy erformed	prior to death?	topsy findings available completion of cause of
Vital Recypician: The label certificate label corrector, page	D I	25. Was case referred to medi	cal			26.P		Check only one)	es 2	No 1 Y	es 2 No
F Vita		examiner? 1 Yes 2 No 27. Manner of Death			ER/Outpatient		Other	Nursing Home 5		injury occurred	r: Scene
on of ' ending Ph ath. or: After i the funeral	1 X Natural 5 Pe	28a. Date of (Month, D	Yes 2		IIDE IIOW	injury occurred					
Division os pipal or Attending spital or Attending sours after death. neral Director: After filled in by the function:		3 Suicide 6 Co	build not be	of Injury - At ho	ome, farm, stre	et, factory, offi	ce building, etc		on (Stree		ral Route Number, City
Lie bour by		Homicide 29a. Certifier 1 Certifying	Physician: To the best of								
To the Ho within 24 To the Eucomplete		29b. Signature and title of cert	xaminer:On the basis of and manner stat	examination ar ted.	nd/or investiga		nion, death occ	curred at the time,		place, and due to the	
5-Parp		anetz	•				.C.M.E.			une 24, 2009	· /// ·//
		30. Name and address of pers	on who completed cause ssistant Medical Ex		23a) 111 Penn S	Street, Balt	imore. MD :	21201			_
Stat		31. Date filed (Month, Day Yea	ar) 32 Regi		· far						
Registra	17		2009 ann	and be	. 7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2009 June 22, Clarence Goodrich Young, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Thomas More Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F 89 **Director** 579-12-6351 Dec. 10, 1919 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1⊈Yes 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1110 Galloway Street, NE by Funeral 20011 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∑Yes 2 □ No 1943 − If Yes, Give Year or Dates: 1945 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 X Married 1 ☐Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced er than "nature , the Medical E Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Federal Government 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Lewis Young ၉ Emma Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen J. Young - wife 1110 Galloway Street, NE, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 6/27/09 Brentwood, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bell & Johnson Funeral Home, P.A. 21. Signature of Fun ral Service Live see 6503 Old Branch Ave., Temple Hills, MD 20748 a /t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTERIOSCIENCTIC Cardovischil **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pus to for as a consequence of) physician and the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Infarction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Encephalopal 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760. attending p P.O. I been signed by the should be detached of Vital Records, cate has page 2 s Hospital or Attending Physician: After Division ours after death.

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filled in by the fur To the Hospital within 24 hours a To the Funeral Completely filled

death

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Baltimore, Maryland

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(Check only one)

29b. Signature and title of certifier

29a. Certifier

ensbury Rd thyatts. He MD 2008

31. Date filed (Month, Day, Year)
JUN 2 3 2009

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:23 PM Month **Physician** Helen Allan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A 9. Birthplace (State or Foreign Country)
Scotland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 23, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1908 Months Days 1 □ M 2 🗓 F 100 072-12-1875 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 7 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is not a leave to market than the market or market. 1 ☐ Yes 2 No Catonsville Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 715 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) altimore, Maryland 17. Father's Name (First, Middle, Last) Be Janet Miller Unk. Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 2344 Cambridge Walk Baltimore, Maryland 21224 Janet D. Allan, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 07/04/09 21. Signature of Funeral Service Licencee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SHOCK Immediate Cause (Final SEPTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):

CHOLAN COITS Examiner Sequentially list conditions, if any, leading to including cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CATON AVENUE BALTIMORE MD ZIZZI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 1/2001

ate 31. Date filed (Month, Day, Year)

32. Degistrar's Signature

Deve S. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per th 8893 7-8-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician haiasta Akhtar JULY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hopice Baltimore Randallstown - Northwest If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Manth, Day Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months Days Hours 060.74.2667 Pakistan Director 06 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location show If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Experience runs to positive at 1 Yes 2 □ No **Funeral Director** MD **Baltimore** death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 2908 Her Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Pakastani Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) it of Health and Mental Hygiene. If Item 27 is marked other than Elementary/Secondary (0-12) Cab Driver Transportation 11th arage Ά 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mubarik ပ Trans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Apt. B Agmina Bobe AKHTAY Baltimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 8010 09 Memorial Park WINDSOY MILL MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility ghn C. Greene Funcat SUS 21. Signatus of Funeral Service Licensee an au -Road Plandulstown MD 21133 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin :) disease or condition resulting in death) **Physician** Acuts. CGVGbVa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy this certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown MD Burton Dabbig 31. Date filed (Month, Day, Year) strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Lynne Albertini July 5, Nancy 10:02 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico 216 E. Church Street Hebron If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/22/1954 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 🕱 F 218-34-6671 55 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No Wicomico Hebron Maryland 10g. Citizen of What Country? 10e. Street and Number 216 E. Church St. 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) food service 12 waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marilyn Cortes Edward Constantine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3000 Falcon Court, Apt.1-A, Westminster, MD21157 Rachel Beatty/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-10-09 Lake View Memorial Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dauge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Expriner must be notified at once.

Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	- 2
Part II. Other significant conditions	CO

Comple							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical					26. Place of De	eath (Check only one)	
2	examiner? 1 Yes 2 No	F	lospital: 1 Inpatient 2 I] ER/Outpatient	3 🗆 [OOA Other: 4 In Nursing	Home 5 Residence	6 ☐ Other (Specify)
ation:	27. Manaer of Death 1 Natural 5 Pending 2 Accident investig	ition	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how injury	y occurred
Certific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, ify)	, facto	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)	
ca			sician: To the best of my knoner: On the basis of examination) and manner as stated. I place, and due to the cause(s)

	29b. Signature and title of certifier	
I	30. Name and address of person who con	21

29c. License number D54127 29d. Date signed (Month, Day, Year) 717/09

pleted cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) JUL 0 8 2009



Salichun Mn 21804

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert D. Biggers July 2, 2009 10:30 A ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 241 E. Main Street, Apt. Elkton Cecil 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1**∑**M 2□F Months Days Hours 57 Director 217-64-2294 NOV 17. 1951 New Mexico Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notfiled at MD Cecil Elkton 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 241 E. Main Street, Apt. 4 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:1971-73 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Biggers Mildred မ Kennard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nenna Marie Biggers, wife 241 E. Main Street, Apt. 4 Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 **X**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) Metro Crematory, Inc. 07/08/09 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknown **Physician** rehos disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed 1∐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after dea... ral Director: Aft 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 🔟 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) 20023322

State

Registrar

achder 8MD

SACHDEN MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elken MD 21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ٧. 7:30a M Alverta Brown 2009 July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville **Baltimore** 6616 Altamont Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min Months Days Yrs 216-09-6635 97 FEB 19, Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedcal Event and the notified anonce. MD Catonsville 1 ☐ Yes 2X No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 6616 Altamont Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**No Specify: White Completed by 3 ₩Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ward Lillian Wilkerson Ashby ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2450 Fairfield Road John M. Brown, son Gettysburg, PA 17325 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Meadowridge Mem. Park 07/10/09 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility MacNabb Funeral Home, P.A. 120 301 Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Onset and Death year Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsectionne offi The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) o been signed by the should be detached 9 HInknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe 1 ☐ Yes 2 ☐ No certificate l 1 ☐ Yes 2 ☐ No or Attending Physician; 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation I Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Prin))

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:55 p Dr. Ernestein Walker Baylor Jul 4, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Village If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 259-36-3218 Georgia May 26, 1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Exeminer must be notified at Director 1 Yes 2 □ No Baltimore Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 8800 Walther Boulevard U.S.A by Funeral 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∏No If Yes, Give X Year or Dates: 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-003 Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If Item 27 is marked other than any injury or other traumath. Elementary/Secondary (0-12) College (1-4or 5+) Morgan State University History Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tommie Lee Walker Leroy Walker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6435 Lehnert Street Baltimore, Maryland 21207 Michelle B. Caldwell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) 5 ☐ Other (Specify) 07/04/09 Baltimore, Maryland Arbutus Memorial Park 22. Name and Address of Facility 21. Sign turn of Funeral Service Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 2121
b not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CINO stage /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1∐Yes 2⊿No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 √Unknown 1 🗀 Yes 2 Mo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2-No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL

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2. Registrar's Signature

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	R	For State			Cert	ilicate o	Death		2. [Reg. Date of Death		3. Time of Death
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		7935 Caldwel					Pasadena				Anne Arunde	
Funeral		. Social Security Nur	mber 6. S	ex 7.	Age (In yrs. la	st birthday)	If Under 1 Y		Min			sirthplace (State or Foreign Country)
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ath wi	Funeral		d 2 X Marrie	Armed Ford		1f	Yes, specify Cu	ban, Mexican,	Puerto Rio	can, etc.)	White, etc	
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ours af	d by	15. Decedent's Edu	ucation (Specify	only highest grade	completed)	16a. Deced	ent's Usual Occi most of working	upation (Give I life, DO NOT	kind of wor use retired		16b. Kind of Busines	ss/industry
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5-0036 fled within 72 Hygiene. d other than the Medical	Completed	12				Se	lf Emp	18,Mother	's Name (F	First, Middle, M	aiden Surname)	Company
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Ex. miner must be notified at once	To Be	19a. Informant's Nar						Street and Nun	nber or Ru	ral Route Numi	per, City or Town, S	
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Baltimore, permit. Pages I an Oepartment of Hea Important: If iter injury or other tr		21. Signature of	Taral Service Lic	ensee		22	Hame and Add	BROTh	ĕrs	Funera	al Servi Itimore,	ce 01017
Per Per Per Injuly		Tel	rla	DC	40		1300 E	utaw	Plac	e, Ba	timore,	Md. 21217 Approximate Interval
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		or condition resulting		b.	consequence	Oi).						
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Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and compleated filled in whe funeral director, page 2 should be detached for use as the burial - transi	Physician/Medi	IF FEMALE: 23b. Was decedent	preopent in the		outcome of pre	egnancy	Fatal dogsth	3 Ector	oic pregnar	ncv	23d. Date of de Month	Day Year
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Divisior To the Hospital or Attend within 24 hours after death. To the Forneral Director:	Medical	(Check only one)	Medical Exam	niner: On the basis	of examination	n and/or inve	stigation, in my	opinion, death	occurred a	at the time, dat	e and place, and du	e to the cause(s)
To t With To t	Pa	29b. Signature an		and mariner.	stated.			License numb			29d. Date signe	d (Month, Day, Year)
	-	1/11	1/1/	2				O.C.M.E.			June 27, 20	09
		30. Name and add	dress of person	who completed cau	use of death (I	tem 23a)				D 04004		
5			exander MD	. Assistant I	Medical Ex	aminer	111 Penn S	treet, Balti	more, N	21201 טו		
	Stat	e 31. Date filed (Mo		Life	Registrar's Sig	nature A	ald					_ =
Reg	istra	L \\	11 082	III A MARCO		9.17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:33 AM TRAR 2009 AMUR /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** ALTIMOR OALTIMOR &
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠ M 2□ F 78 Director 05/11/1931 Maryland 213-28-1199 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Wedeal Even in it is ust be multified at 1 ☐ Yes 2X No Director Maryland Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12411 Eastern Avenue 21220 U.S.A. by Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Widdral Evan, in once. 1 ∑Xes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify Specify: White Korea 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Libern Bragg Georgia Moser ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Bealmear (Daughter) 13206 Choptank Road, Baltimore, Maryland 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory, Inc 07/10/2009 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Functor Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cause (Final diseas, or condition result in in death)

a. METASTATIC ADENDCARCINOMA Physician /Medical Due to (or as a consequence of): Examiner PRIMARY UNDETERMINED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) signed by the at d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☑No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Hospital: _ 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 To the Hospital within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Kafeena

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Bacchus

Day, Year)

29c. License number - NPI

29d. Date signed (Month, Day, Year)

Rth GREENE STREET BALL MORE, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 7 PEX 2008 MARTINA 3.45 AM (brown 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORS SAMALITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min Months Days 1 □ M 2 € F 220-20-0755 Maryland 82 10/08/1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State to Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6507 Fairdel Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Book Keeper Plumbing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Kemp Mary Willis Moffitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 Fairdel Avenue, Baltimore, Maryland 21206 Scott Brown (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 07/10/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral School Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Fill the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediat Cause (Final diseas or condition resulting in death)

a.

District (Accessed as a cause) Approximate Interval Between Onset and Death Due to (or as a consequence of): NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): CKNCER Luse Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "indical Explaint." In Item 27 and 27 and 27 and 27 and 27 and 27 and 28 an

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran

the

Director:

within 24 hours a To the Funeral C

filled in by the funeral

the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

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IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 🗆 Yes 9 Unknown 25. Was case referred to medical examiner? 1∐ Yes 2 🗹 No 27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

29b. Signatu

orny	2L	Medical E	xaminer: On the and ma	nner stated
re and	d title	of certifier	•	. 1
W.	- 1	14. 1/	0 -1 0	\sim

Hospital:

28a.

1 Inpatient

Date of Injury (Month, Day, Year)

29c. License number

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSEMWAY MKKK, 5601 LOUGH LAVEN BWD, BALT, MD 21239

31. Date filed (Month, Day, Year) JUL 0 8 2009 32. registrar's Signatury

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** July 05 2009 01:30 PM Ellen Rebecca Benafield /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Preston Caroline 24308 Marlyn Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 16 1 Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days 1 ☐ M 2 ☒ F 87 **1922** Director 235-38-8614 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Pasadena Director Maryland Anne Arundel 1 ☐Yes 2 XNo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21122 1953 North Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Services 12 Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Dailey David Gratton Harman ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24308 Marlyn Drive, Preston, MD 21655 Anna E. Klapka (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 07 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2009 22. Name and Address of Facility ture of Fundal Service 21. Sig Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Fina **Physician** Cardiomyor Hypertensive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if only lead to limit to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident or Attencate after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Prestoner Ledn 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	ryland / Dep	partment of H	lealth and M	ental Hygi	ene	01670
			State Registrar		Ce	ertificate of l			g. No. 4009	21012
	Physicia	an	1. Decedent's Name (First, Middle		IDD			2. Date of Death Month	Day Year 27, 2009	3. Time of Death 9:40 P M
	/Medic		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death	301UZ 2	4c. County of Death	<u> </u>
	Examin	er	3621 GREEK		CAD	BAL	TIMO	RE	NIA	
	Funeral		5. Social Security Number	6. Sex 7. Age 1	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign
	Director		219-32-2170 Usual Residence of Decedent		7 7 115.			MARCH 9	,1932 N.C	AROUNA
	yland how at		10a. State 10b. County	,	10c. City, Town or	Location				10d. Inside City Limits
	e Mar 8a-f s	cto	MARYLAND N	IA	BAL	TIMOR	<u>E</u>			1 MYes 2 □ No
	a or 2	Dir	10e. Street and Number	VALE RO	AD	10f. Zip Code	209		Og. Citizen of What Cou	nuy?
	ms 23	Funeral Director	3621 GREEN 11. Marital Status	12. Was Decedent E		B. Was Decedent of H			14. Race - Ameri	
ထ္ထ	or ite		1 ☐ Never Married 2 ☐ Marr	Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give	lo	1 ☐ Yes 2 🕱 No	Specify:	Hican, etc.)	Black, White,	LACK
Ö	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evaniner must be notified at	ed by	3 ▼ Widowed 4 □ Divorced 15. Decedent	Year or Dates:	16a Dec	cedent's Usual Occup	ation		16b. Kind of Business/Ir	
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Maryland	ould be file Mental Hy arked oth atic event	Be	17. Father's Name (First, Middle,	Last)	201/19		18. Mother's Name			
<u> </u>	should and Mer s marke	₽	CHARLIE 19a. Informant's Name/Relations	nin (Type Print)	DAVIS		CARRIZ and Number or Bura		City or Town, State, Zi	ic Code)
	and 2 s ealth ar n 27 is ner trau		HEIEN ADAMS						TIMORE, MI	21000
Sre,	es 1 a of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	ce) D	ate 2	20c. Location - City or T	own, State
Ĕ	Pages ment of ant: If it		1 🏿 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		MT. ZION	I CEMETE	RY 07/0	3/2001/	ANSDOWN	LE, MARYLAND
Baltimore,	permit. Pages 1 al Department of Hee Important: If item any injury or othe once.	9	21. Signature of Funeral Service	icensee Will	liams 6	22. Name and Address SOSEPH H. 2140 N. FU	SS OF Facility BROWN LTON AVE.	BALTII	MERAL H	ome 21217
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. Do not e					Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)		gestive	Hear	+ Fai	wre		N 2 Y
	/Medical Examiner		roodining in doubly	Due to (or as a	a nsequence of):	P	1 D			~10 00
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Suc to (or as o	a eunsequenes of):	6 630	171	75135		
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	6. <u>Co-</u>	a consequence of):	Artry	Disea	د، ف		
760,	be exician burial	cal E	Tooling III down, Lace	Due to (or as a	a consequences or,					
687	ificate g phys			d						
ŏ	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ☐ Ectopic pregnanc	v		23d. Date of deli	very Day Year
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 ☐ Other (specify) _			World	Day Tour
σ.	w requires that the d been signed by the should be detached		Part II. Other significant condition	ns contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
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o	ding Physician: The h. h. After this certificate h. funeral director, page	n: T	27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Injui			ow injury occurred	3119)
Sior	tendin Jeath. tor: Af the fur	catio	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation		M	Yes 2□No			
ĭ	or Att	Certification: To	3 Suicide 6 Could a determ	ined 28e. Place of Injubuilding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
_	To the Hospital or Al within 24 hours after o To the Funeral Direc completely filled in by		29a. Certifier 1 Certifyir	ng Physician: To the best	of my knowledge, de	eath occurred at the ti	me, date and place,	and due to the c	ause(s) and manner as	s stated.
	the Horin 24 the Fu	Medical	one)	Examiner: On the basis of and manner sta						
	Viti Viti Con	Σ	29b. Signature and title of certifie	71.1		29c. Licens	se number 3 8 7 4 -		9d. Date signed (Month	
			30. Name and address of person	who completed cause of d	eath (Item 23a) (Tur			•	70	2/09
			May T Be	hrens me	57/ 6 P	J. Rollin	Road S	vite 107	Balto.	85515 AM
	Sta		31. Date filed (Month, Day, Year)	who completed cause of d	ar's Signature	del	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Charlie Lee Brown 30 2009 Ture /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LANDAM uncerite If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 50 Director March6,1959 Louisiana 433-13-8977 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, II at Medical Event in the institute to institute the institute of the control M Yes 2 No Director Orleans New Orleans Louisand 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5535 Pauline 70126 U.S.A. Funeral Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1√ Never Married 2 Married 1 □Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. Specify: Black 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 5+ Out Reach Coordinator Counseling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UHKNOWN Anna Lou Brown ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Johnson 4842 Strausbourg Place, New Orleans, Louisiana 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt.Olivet Cemetery 7-8-09 New Orleans, Louisiana 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland 21214 marguelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterioscherotie **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off certificate be executed burial-1 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) I ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Division of Vital Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examine??
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\bigcap \) Nursing Home \(5 \bigcap \) Residence \(6 \bigcap \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 27, Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 | Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. the

State Registrar 29b. Signature and title of certifier

30. Name and address of person who conserved cause of death (Item 23a) (Type, Print)

32. Registrar's Si

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20h Perater of Wary and Partment of Health and Mental Hygiene for State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Banks PM 9:15 09 Genester 01 /Medical 4c. County of Death not institution, give street and number Examiner MUnder 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country ō USA 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items Was Decedent Ever in U.S. 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) unselor is marked other Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Be be 1 ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Sister-in-law/ Natid Apt.C 20a. Method of Disposition 20b. Vagett a sposition (Alame o Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-list only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. L immediate Cause (Final disease or condition resulting in death) Physician Mans /Medical Du to (r as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 □No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death,

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 1 ☐ Yes 2 11No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ong) Hospital: Other: 4 Nursing Home 5 Anesidence 6 Other (Specify) 2 1 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9512 Harford Rd 21234

DHMH 17 Rev 1/2001

State Registrar

Mohammad Reza Rahnama

0 8 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore

,MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2009 21675

_		R	- For State Centificate of Death Reg. No. legistrar 2. Date of Death 3. Time of Death									
	hysicia	ın/	Decedent's Name (First, Middle,Last)						Month July 3, 20	Dav	Year	0050 hrs
Ieu	al Examir		Robert Wayne Bunch 4a. Facility Name (if not institution, give street and number)	4	b. City, Tow	n, or Lo	cation of		J., 4, 20	4c.	County of Death	1
			Washington County Hospital Hagerstown								Vashington	
	Funeral			Social Security Number 6. Sex 7. Age (In yrs. last birthday)							Foreig	thplace (State or
	Director		212-88-4748 1 ^X _M 2 F 42	Yrs.	Months	Days	Hours	Min.	July	15,	1966	ountry) CO
		- 1	Usual Residence of Decedent									10d. Inside City Limits
	any	ſ	10a. State 10b. County 10c. City, Town		∘⊓ larksv	11	_					1 Yes 2 X No
0	and show	ь	MD Howard	<u> </u>			<u>e</u>			10a Citi	zen of What Cou	
(75/)	ne Maryland or 28a-f show fred at once.	Director	10e. Street and Number		10f. Zip Co		1029			109101		USA
2	h the		13715 Triadelphia Mill Road	12 10/2	s Decedent	of Hisp	anic Origi	n? (Spec	ifv Yes or N	lo-	14. Race - Ame	rican Indian, Black,
	ith with lems 2 st be r	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	If Y	es, specify (Cuban,	Mexican,	Puerto Ri	can, etc.)		White, etc.	ŀ
	er dea		Wildowed 4 Divorced If Yes, Give Year	1	Yes 2	₹ No	specify:				specify:Whit	ce
	5-UU30 jied within 72 hours after death with the Maryland Hygiene dother than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	ē	15. Decedent's Education (Specify only highest grade completed) 16a	a. Deceder	nt's Usual Oc lost of worki	cupatio	n (Give k	ind of wo	rk done	16b. l	Kind of Business	/Industry
	72 hou n "nai al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)					230 1011101	-,	,	Transpoi	etation
000	rithin sne.	ם	9	Tru	ck Dr			c Name (First, Middle	- 1	•	tation
L.	Z13-003c be filed within ntal Hygiene. rked other tha ent, the Medic		17. Father's Name (First, Middle, Last) Clarence Eugene Bunch						Kay D:			
ç	Z1Z13-UU30 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	40 - Informantia Namo/Rolationship (Type Print)	19b. Mailin	g Address	(Street	and Num	ber or Ru	ral Route N	umber, C	City or Town, Sta	te, Zip Code)
2	and 2 should and 2 should be altern 27 is not traumatic	ř	Mrs. Robin R. Bunch (Spouse)	13715	Tria	delp	hia	Mill	Road	Cla	rksville	e, MD 21029
			20a. Method of Disposition 20b. Plac	e of Dispo	sition (Name ther place)	of cem	1		Date		Location - City	
	10Fe ages 1 nt of H nt: If i		A11	Count	y Cre			7/6/			ykesvil	le, MD
-	Saltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	H Δ ² T	Name and A	ddress	of Facility	OME	& CHA	PEL.	P.A.	
	Per Per Injuri		12 M M M M M M M M M M M M M M M M M M M									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Between Onset and Death						
	/Medical Examiner		Immediate Cause (Final disease a. Narcotic intox	icati	on							
	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or condition resulting in death) Due to (or as a consequence of):									
		e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
		i E	cause. Enter Underlying Cause (Disease or injury that initiated Company that initiated Due to (or as a consequence of).									
	ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence oi).							_		
	Accords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be deached for use as the burial - transit	cal	X UNPENDED AMENDED 23a,27,2	8a-f,	perME	g89	93 7/	/10/0	9 TT			
	50, te be a nysicia e buria	n/Medical	IF FEMALE: 23c. If yes, outcome of pregnar	ncy						2	23d. Date of deliv	•
	587 rtifica ling pl	. =	23b. Was decedent pregnant in the 1 Live birth		etal death	3	Ectopi	ic pregnar	псу		Month	Day Year
	OX 6 ath ce attend	Physicia	past 12 months? 1 Yes 2 No 9 Unknown g Unknown	5 (Other (Spec	ify)						
	cords, P.O. Box 6 law requires that the death cer has been signed by the attendi 2 should be detached for use:	독	Part II. Other significant conditions contributing to death but not resu	Ilting in the	underlying	cause (given in P	art I.				to the cause of death?
	P.C s that gned b	6							1	Yes 2		Probably 4 Unknown
	ds, equire een si	Completed								24a. Was an 24b. Were autopsy findings availa prior to completion of cause of		
	COF law r has b e 2 sh	Ē				_				erformed es 2		
	tal Rec cian: The certificate ector, page	ပြ				26.Place	e of Death	(Check	only one)			
	/ital	Be	examiner? Hospital:	R/Outpatie	ent 3 D	OA	Other ₄	Nursin	g Home 5			ther:
	28d. Describe how injury occurred (Month, Day, Year)											
Pending Panding Pandin							-t d Number o	- Pural Pouta Number City				
							1101 Di	ial Hwy				
Solution determined (Specify) 4 Homicide Hagerstown, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state of the control of the control of the time date and place, and due to the cause of the time date and place, and due to the cause of the time date and place and place and place.								stated.				
	n 24 h	<u> </u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner:On the basis of examination and	e, death oc d/or investi	curred at the gation, in m	e time, c y opinio	n, death o	occurred a	at the time,	date and	place, and due	to the cause(s)
	To the Ho within 24 To the Fu	Jed	and manner stated. 29b. Signature and title of sertifier				se numbe					(Month, Day, Year)
	./ ^	-	121/1/	ر		O.C	.M.E.			J	luly 3, 2009	
0			30. Name and address of person who completed cause of death (Item 2	23a)								
L	June 1		Jack Titus MD. Deputy Chief Medical Examiner	111 F	enn Stre	et, Ba	ıltimore	, MD 2	1201			
		State	31. Date file Worth 0 8 2009 32. Registrar's Synatur	bar								OCHE
	Regi		DOL O COUS JOSEPH JO.									OCME

ORIGINAL

09-05098 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Frank Brice 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Frank Brice A.K.A. Time of Death Decedent's Name (First, Middle, Last Physician/ Month Day June 28, 2009 0906 hrs **Medical Examiner** Marcus L. Williams 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) NA Baltimore Sinai Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** 5. Social Security Number 6. Sex Foreign Min 32 Months Days Hours Director 220-86-7304 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 altimore or 28a-f show with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21223 rederick 21229 venue Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. frican Armed Forces? 2 Married Never Married Yes 2 · No Yes 2 No specify Divorced f Yes. Give Yea traumatic event, the Medical Examiner "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "" Baltimore, MD 21215-0036 11th Grade nTrepreneur 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be vice rank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3270/ 19a. Informant's Name/Relationship (Type, Print) Mother 380 Apt. #206 asselbery oncshel raldine 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition ury or other Burial 2 X Cremation Metro Crematory 3-09 ansdowne ion Cem Donation 5 Other Specify 22. Name and Address of Facility WYlie F 21. Signature of Funeral Service Lice uneral Home Saltimore plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a. Head and Neck Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and #1 per ME g893 //8/09 TT **#10f, 20a-b, per Fh g893 7/17/09 TT** Physician/Medical XAMENDED UNPENDED attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 ned by the atte Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed b 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes No ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Other DOA Nursing Home 5 Residence 6 Inpatient 2 P ER/Outpatient 3 After this 1 Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject beaten Jun 28, 2009 Natural Yes 2 V No Pending Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 24 Wyndmoor Place, Woodlawn, MD (Specify) Parking Lot 4 V Homicide 29a. Certifier 1 (Check only one) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician; Medical 2 Medical Examples on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the nd manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number

Registra DHMH 17 Rev 1/2001 **OCME 2006**

State

Mary G. Ropple MD. 31. Date filed (Month, Day, Year)

08 200

ORIGINAL

s of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

2. Registrar's Sign

June 29, 2009 O.C.M.E

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** BLUM 04:45P ^M **EUGENE** 2009 JULY 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ENVOY OF PIKESVILLE PIKESVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 11/14/1922 1 💢 M 2 🗆 F OH 089-16-7359 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or : ury or other traumatic event, the Medical Examiner must be in 3204 NERAK ROAD 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES LIFE INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BLUM BESSIE GOLDSTEIN DAVID ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 NERAK ROAD, PIKESVILLE, MD 21208 CHARLOTTE BLUM / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ABurial 2 □ Cremation 3 □ Removal from State DHEB SHALOM MEM PARK 107/07/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lic 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CKD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Day 5 Other (specify) ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? res 2/2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f the Hospital

> Anne L. Villan 31. Date filed (Month, Day, Year) Registrar JUL 0 8 2009

29b. Signature and title of certifier

CRNP

S, Emp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Cross 11:00 PM amse 30 2009 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 6810 Bank Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1**∑** M 2□ F Months Hours 77 11/27/1931 North Carolina Director 213-26-3461 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, it. Medical Evanines must be notified at once. 1 XYes 2 No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21224 6810 Bank Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give Year or Dates: Completed by 3 🗆 Widowed 4 🗆 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Crane Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Viola Cicero Cross ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bank Street, Baltimore, MD 21224 Cross/ Daughter 6810 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2/2009 Hanover, Maryland Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician eizun /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2X No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 No death. investigation neral Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital within 24 hours a To the Funeral I

State Registrar

29a, Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 0 8 2009

30. Name and address

36 541134)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

9000 Stoney Point Pkwy. Richmond, VA 23235 MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:00 a Joe Robert Carpenter Jul 5, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Severn 8417 Pioneer Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days Min 1 ☑ M 2 ☐ F Texas Director Jan 18, 1947 62 458-78-8852 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State d other than "natural", or Items 23a or 28a-f show event, the Medical Experience must be rutified at 1 ¥ Yes 2 □ No Director Severn Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21144 8417 Pioneer Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No 1969 Specify: Black <u></u> 3 Widowed 4 Divorced 1071 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military 7 is marked other traumatic event, II 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Rose Walker Joe Robert Carpenter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health &
Important: If item 27 is
any injury or other traus 8417 Pioneer Drive Severn, Maryland 21144 Mary Carpenter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pasadena, Md. 07/11/09 4 Dopation 5 Other (Specify) Mt. Zion Church Cemetery 21. Sign ture Funeral Service Licen 6 Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Cirrhosn 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** orgentine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Coyonagu and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 No P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Kidney 3 Probably 4 ☐ Unknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe the Hospital or Attending Physician: The 2 🗆 No this certificate 1 ☐Yes 2 No 1 ☐ Yes **Division of Vital** director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 National 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation ne Hospina. In 24 hours after death. The Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 St Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 09 504 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATLURI 8109 RITCHIE HIGH WAY; PASADENA SRIDHAR. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 Carmona /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Northwest Hospital Seasons Hospice Baltimore Randallstown 9. Birthplace (State or Foreign Country) Chile 8. Date of Birth 11-18-1960 Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔀 F Months Days Min. 48 047-64-9373 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Experiment must be notified at 1 ☐Yes 2X No Director MD Anne Arundel Odenton 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 317 L Eagle Landing Court Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 Married Specify: 1 ☑Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Caucasian Chilean Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beauty College (1-4or 5+) Elementary/Secondary (0-12) of Health and Mental Hygiene. Hair stylist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrea Carmona Romo John ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5930 Millrace Crt. #104, Columbia, MD Mr Robert Lussier/companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/8/2009 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 21. Signature de uneral Service Licensee M01364 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) STAGE LIVER END /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed ALCOHOL and burial-tra Due to (or as a consequence of) physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 📉 No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be def þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No Hapatoranal syndrama Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **5**No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Hoshice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

To the I

State Registrar

and title of	ertifier)	,
Wal	1 JUS	unten

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah I Burton 2835 Smith Ave Suite 200 Baitmore MD bourah

and manner stated.

Medical

29a. Certifier (Check only one)

29b. Signatura

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

2. Date of Death

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10e, 19a, perFH, G893, 7/8/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 ear July 3, Anita Carroll Charlotte **Physician** 11:15 pM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1 □ M 2 □ F 67 033-30-5880 26, 1941 MA Nov. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Columbia MD Howard 1 Yes 2 No Director with the 10e. Street and Numbercious End Court 9131 Cracious & Court Unit 304 10g. Citizen of What Country? 10f. Zip Code ō 21046 USA or items 23a death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes XXX No Specify: 3 3 Widowed 4X Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Law Firm Legal Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Booker Offley Charles ၉ 19a. Johnnant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerger Road, Ellicott City, MD 21043 John Offley / Son 5334 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Forest Hills Cemetery 7/9/2009 Boston, MA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensae Dorota Marshall 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 Marsh Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a resequence of): Examine law requires that the death certificate be executed burial-transit OP 251 4 and Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 ∐Yes 2 KNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date ≸igned (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, 600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			1.7	who completed cause				Lin Sau	are DR	Balto	md 212
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2009 Lola Fay Corbin **Physician** ам July 6, 8:37 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Hours Min Months Days 1 □ M 2**X** F 87 525-70-4728 Oct. 07, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County MD Montgomery Gaithersburg TX Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 USA 98 Nina Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☐No Specify Completed by 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Hardware Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be T.Roya1 John Compton Ivy ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 98 Nina Court, Gaithersburg, MD 20877 Sandra Deaton / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State 111/09 Portales Cemetery Portales, NM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Charles L. Stevens Funeral Home Inc. ushall 1501 East Fort Avenue, Baltimore, MD21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Bradylardia Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The introduction is a for as a foundation of Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Myocardial Perforation resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Sepsis Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) the 8 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autonsy perform 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XXNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sine De Jalli M.1) 200 68080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE SIRBESHA JALLE M.D

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 8 2009

32 Registrar's Signature

Baltimore, Maryland 21215-0036

	For State Registrar	_,	aryland / Dep <i>Ce</i>	rtificate of		Re	g. No. 2	09	21685
	1. Decedent's Name (First, Middle, L	.ast)				Date of Death Month	n Day	Year	3. Time of Death
an al	Gla	dys Leona	a Cimagl	Lia		July 6		_	7:20 A M
er	4a. Facility Name (If not institution, g 6554 St. Helena				r Location of Death		4c. County		
			e (In yrs. last birthday	<u> </u>	imore Cit			N/A 9. Birthp	lace (State or Foreig
	214-14-9994	1 □ M 3/7/F	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 20		Coun	yland
	Usual Residence of Decedent		50			bept. 20	1922		
.	10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits 1 ✓ Yes 2 ☐ No
Director		/A			Ba1	timore C		14/1	
	10e. Street and Number 6554 St. Helen	a Avenue		10f. Zip Code			0g. Citizen of		
erai		12. Was Decedent	Everinitis 13		222 Hispanic Origin? (Sp.		United 14. Ba	ce · Americ	
Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	Armed Forces?			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ick, White,	
ğ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 21K No	Specify:		Specia	fy:	White
ted	15. Decedent's	Education	16a. Dece	edent's Usual Occup	pation during most of work	ina I	16b. Kind of B	Business/Inc	dustry
Completed by	Elementary/Secondary (0-12)	College (1-4or	`life.	DO NOT use retire	d)		01	-1 /200	, A
ပ္ပ	8 Years			Clerk_	18. Mother's Name		Cleric	<u> </u>	A
Be	17. Father's Name (First, Middle, La Walter Allan					rinne Ly			lge
٩	19a. Informant's Name/Relationship		ghter) 10h Mail	ling Address /Street		-			
	Mrs. Maria Elen	a Whitlow			lace Dun				
	20a. Method of Disposition			osition (Name of ematory or other pla			20c. Location		
	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Sacred	ematory or other pla Ht. of Je	sus Cem.	7/10/200)9	Dunda	lk, MD
	21. Signature of Funeral Service Lice				ess of Facility Funeral			k. In	10.
	125 GC				Ave. Du				
	23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death. Do not er						Approximate Interval Between
	Immediate Cause (Final disease or condition	1	4 Cancer						Onset and Death
	resulting in death)	u.	consequence of):						
_	Sequentially list conditions,	b. Chro		chie pol	money di	seave			
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a rousequence of)r						
xan	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
<u>a</u>		d							
edic		u							
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic pregnan				ate of deliv	*
icia	in the past 12 months? 1 ☐ Yes 2 No	4 Pregnant		Other (specify)			N	Month	Day Year
hys	9 □ Unknown	9 □ Unknown							
by F	Part II. Other significant condition	s contributing to death I	out not resulting in the	underlying cause gi	iven in Part I.		_		the cause of death?
ted						120	es 2□No	3 PIO	bably 4 Unknow
Completed						24a. Was a autops	sy	prior to co	opsy findings availat ompletion of cause o
S						perfor 1 □ Yes	227No	death? 1 ☐ Yes	2 🗆 No
Be	25. Was case referred to medical examiner?	Haspital		0:	26. Place of Dea				
2	1 Yes 2 No	Hospital: 1 inpat		ent 3 🗆 DOA	her: 4 Nursing H	ome 5 Resid 28d. Describe h	lence 6 0		ify)
ion	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, D	ay, Year) 200. Fine	. Wo	ork? □Yes 2□No	200. Describe ii	ow injury occi	21100	
Certification:	3 Suicide 6 Could no	t be lass Blood of In	 njury - At home, farm, s					nber or Rui	ral Route Number,
iri	4 ☐ Homicide determin	building, e	tc. (Specify)			City or Tow	n, State)		
	(Check only 2 Medical E	Physician: To the bes	t of my knowledge, de of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the or cred at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	one)	and manner s	tated.		nse number		29d. Date sign		
	and Cinnet and the Committee	1.1				1 '			
Medical Co	29b. Signature and title of certifier	h X IA		No.	065744		lade	GHM	2009
	29b. Signature and title of certifier 30. Name and address of person w	alle			065241		July	Gth,	2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 2009 Year Margaret Genevieve Capitano July 4:45 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Year) Months Days 1 1 M 2 X F 06-06-1919 90 Maryland 213-16-6946 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Ves 2 No Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 917 E. Belvedere Avenue 21212 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Specify White 3 🗌 Widowed 4 🗆 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Salvatore Capitano Maria Santina Piraino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11610 Masters Lane Unit 113 Berlin. Maryland 21811 Mr. Dennis Capitano - Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 07-10-2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. and I. Baltimore, Maryland 21214 Hartook 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 2/00 Due to a s a conse uence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify)

1 ☐Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

JULY 7, 2009

TIMONIUM, MD 21093

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evanimer must be notified at

Is marked other than "natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, that In

Director

Completed by Funeral

Be

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death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,64

P.0.

Division of Vital Records,

CAPITANO

WARGARET

the death certificate be executed physician and is the burial-trans attending p been signed by the should be detached Physician/Medical Examiner

2

Completed

Be

Certification: To

Medical

29b. Signature and till of certifier

page 2 s certificate director, Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐Yes 2 No 9 ☐ Unknowf 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 21240 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

01

within 2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 D 2300 DULANEY VALLEY ROAD

31. Date filed (Month, Day, Year)

29c. License number

State Registrar

31. Date filed (Month, Day, Year)- ---

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHIVAKUMAR NARAYANAN, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BULD,
BALTIMORE 21239 Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 6, 11:30Am **Physician** 2009 Gladys Clipper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Hill Assisted Living Dayton Howard 8. Date of Birth (Month, Day, Dec 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Days Hours Min. Months 1 □ M 2 □ F 100 212-32-1032 1908 MD Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at MD Cooksville 1 ☐ Yes 2 ☐ Xio Howard Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21723 USA 2328 Millers Mill Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: black Maryland 21215-0036 1 □ Yes 2 □**X**No Specify: 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Howard Co. Schools Elementary/Secondary (0-12) College (1-4or 5+) cafeteria manager permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, I'va. once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Clark Thomas Allen ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2344 Millers Mill Rd., Cooksville, MD 21723 Deborah Young (granddaughter) 3altimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bushy Park Cemetery 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-13-09 Cooksville, MD 4 ☐ Donation 5 ☐ Other (Specify) Haight Funeral Home & Chapel 22. Name and Address of Facility 21. Signature of Funeral Service License 6416 Sykesville Road, Sykesville, MD Dage Haight Herbert Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death), last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 □ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ Ho 24a Was an has page 2 autopsy performed Yes 2 this certificate 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manuar of Death within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 009 160 M

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2145 **Physician** PM 2009 Sarah Frances Deeringer Tuli /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Health Care Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | Days | Hours | Min. | Dec. | 8, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 1920 Georgia 215-16-5328 88 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination and be notified at once. 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Apt. 305 21014 USA 555 S. Atwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No White Specify: Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Doctor's Office Receptionist n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marioin King Angel Nestor Staicos ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hydes, MD 21082 12826 Harford Road Marilyn Delcher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/09 Parkville, Maryland Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, of hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 **Physician** 0 /Medical Due to (or as a consequence 🐄 2 MOS **Examiner** Rena Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of): Physician/Medical attending physical for use as the to IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det δ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 2 No 1 ☐Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

he Hospital or Attending P in 24 hours after death. he Funeral Director: After t pletely filled in by the funera the within To the

> State Registrar

cal

29a. Certifier

29c. License number H006781

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Checapeake Drive Bel Air, mo 21014 Basil 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUL 0 8 2009

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 1617 July Ella Dalgliesh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville
If Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 □ M 2 🕱 F Yrs. Dec. 31, 1912 Pennsylvania 96 Director 159-05-0530 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedleal Exercises must be notified at 1 Syes 2 No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20878 United States 547 Helene Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XINo Specify. If Yes, Give Year or Dates: Specify: White <u>ک</u> 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Pages 1 and 2 should be nent of Health and Mental Elizabeth Harrison ပ Lewis Seifin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau
once. 547 Helene Street, Gaithersburg, Maryland 20878 E. Diane Woods/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŻŎ09 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes **Physician** Cardiac Dysrythmia /Medical Due to (or as a consequence of) **Examiner** 1 day Respiratory Distress Sequentially list conditions, it any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 🖾 No P.0. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed? yes 2⊠No the Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \((Specify) \) 1⊠Yes 2∐No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours a

To the Funeral C

State Registrar 29b. Signature and title of

31. Date

DHMH 17 Rev 1/2001

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland / I	Department of Certificate		d Mental Hygi		21691
			Registrar 1. Decedent's Name (First, Middle,	(ast)		Certificate	OI DeallI	2. Date of Death	eg. No.	3. Time of Death
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F	love		Washington A 5. Social Security Number		ospital ge (In yrs. last bi	rthday) If Under 1		rs. 8. Date of Birth		gomery thplace (State or Foreign
	neral ector		217-02-5880	1 □ M 2 💢 F	93	Yrs. Months D	Days Hours M	March 15	, 1916	ountry) India
			Usual Residence of Decedent							
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# # 5	о по	Director	10e. Street and Number			10f. Zip C	ode	10	g. Citizen of What C	ountry?
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and Mer	mat	-	19a. Informant's Name/Relationshi		19	o. Mailing Address (5	Street and Number o	r Rural Route Number,		Zip Code)
IVIC altha	rtra		Vandana Narang	r/ Cranddau	chtar	1024 Fat	on Drive	McLean, V	irginia 22	102
parmit. Pages 1 and 2 Department of Health 8	other traumatic event, the Modeal Examiner must be notified at		20a. Method of Disposition	7 Granddau	20b. Place of	of Disposition (Name ery, crematory or other			20c. Location - City or	
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To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funest after death.	completely filled in by the funeral director, page 2 should		29a. Certifier 1 Certifying	g Physician: To the bes examiner: On the basis	of my knowledg	e, death occurred at	the time, date and p	place, and due to the coccurred at the time.	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician Embree Doris 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Columbia owa 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 D F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "holidal Experient must be neithed at 1 ☐ Yes 2 No Director 10g, Citizen of What Country? 10e, Street and Number Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 than "natural", or Specify: Blac ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eacher 18. Mother's Name (First, Middle, Maiden Surname permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth-any injury or other traumatic event 17. Father's Name (First, Middle, J. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Belationship (Type. Print) Ellicott C 20b. Place of Disposition (Name of cemetery, crematory or other). 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kark 07-11-09 21. Signature of Funeral Sarvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ NO cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐No 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | ₩6 2 ER/Outpatient 3 DOA ၉ Inpatient Certification: 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 30641 Back River Neck Road Baltimore Mayladzen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamesh Sabapatmi 201-109 31. Date filed (Month, Day, Year) State JUL 08 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 694 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 8:15a^M July John Graham Farm<u>er, Sr</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Churchville Harford 3106 Aldino Rd. Social Security Number 8. Date of Birth (Month, Day, Ye 8/2/1935 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F Yrs 73 Virginia Director 215-32-4733 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the "Miclical Exercities or next be notified at 1 ☐ Yes 2 No Director Harford Churchville Maryland 10g. Citizen of What Country? 10e. Street and Number 3106 Aldino Rd 21028 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event han once. 1XYes 2 No 1 Never Married 2X Married Specify: white If Yes, Give Year or Dates: 56–58 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver trucking 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur G. Farmer Bertha L. Armstrong ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3106 Aldino Rd., Churchville, MD 21028 Dolly M. Farmer (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 7/8/2009 West Chester, PA 4 □ Donation 5 □ Other (Specify) R.A.Ferris & Co. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Aberdeen, Maryland 21007 – 339 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Circhusis 3 months /Medical Due to (or as a consequence of): Years Examiner Alcohol USP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be execute Due to (or as a consequence of) 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 □ Yes funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2K(No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending **≯** Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #YOU Aberdeen MO 21001 15 S. Parke rashant 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day 200 gar **Physician** 9:56am M Everett Lee Fralin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4515 Raymond Avenue Carroll Sykesville 8. Date of Birth (Month, Day, Year) March 12 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1 🙀 M 2 🗆 F 1923 86 VA 227-16-0082 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Sykesville MD Carrol1 1 ☐Yes 2XNo **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21784 4515 Raymond Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Tyes 2 No WWII
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction/roads construction foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Laura Schilling Rufus Monroe Fralin ပ 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Raymond Ave., Sykesville, MD 21784 Martha Fralin (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 7-6-09 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Many YYS OYONOY Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 T I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ↑ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, physician s the burial signed by the attending p should be peen s certificate has b lirector, page 2 st within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i

Funeral

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
This is them 27 is marked other than "natural", or items 23a or 28a-f shown mit. If fem 27 is marked other than "natural", or items 23a or 28a-f shown any or other traumatic event, it is when the Erentine from the normal any or other traumatic event.

Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical Completed by Be Medical Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) D23443 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

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1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JULY **Physician** 3,2009 12:10p^M JUANA FONSECA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FUTURECARE CANTON BALTIMORE N/A 8. Date of Birth (Month, Day, Year) SEPT . 12,1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 F 96 PUERTO RICO Director 583-14-4055 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any highly or other traumatic event." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6321 TOONE STREET 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married XXves 2 □ No Specify. 2 **S**₩idowed 4 Divorced PUERTO RICAN WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٩ FELIZ FONSECA BAZILICIA DE JESUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 JUAN FONSECA/ SON GRUNDY STREET, BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 7/7/09 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician homo Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at be detached for 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 st autopsy performe Yes 2 1 ☐ Yes funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hours after le Funeral Dire pletely filled in b Test Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of 20011150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORKES, MO 441 S. ELLWOOP AVE, GALTO, MO 21224 V 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 Joan Gustafson Fuller July 4, 3:30AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 🕅 F Yrs. 82 August 18,1926 New Jersey 579-28-2018 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland North Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5550 Tuckerman Lane #437 20852 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify. 2 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Clara Piper Albert August Gustafson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Kathy Jean Fuller/ Daughter</u> 534 6th Street S.E. Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 6, 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a wider enelmo vas culor Due to (or as a consequence of) neummo Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): D NAM Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 🖼 o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Menus 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760, , Joan

Examiner Physician/Medical ۵ Be Completed Certification: To

Funeral

Director

r than "natural", or items 23a

of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, Item

Department of H Important: If iter any injury or ott once.

Physician /Medical

Examiner

the Maryland 3a or 28a-f show t by notified at

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1.P Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

who completed cause of death (Item 23a) (Type, Print) (1) 100 , 3200 Down Oays, Blod,

State Registrar

Medical

31. Date filed (Month, Day, Year,

4 Homicide

determined

 Registrar's Signature rack

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County Examiner 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age Funeral Social Security Number Days Year) Months Hours 1 □ M 2 □ Ò 5 37-36-4710 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12 608 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 ☑ No Completed by 3 Widowed 4 □ Divorced America th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Olth Grade Omesti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wouldce oshua sireene ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trauonce. 519 lony arroll ltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07-11-09 Consdowne 4 ☐ Donation 5 ☐ Other (Specify) LIDIN em. 22. Name and Address of Facility 21. Signatu - Filheral Service Lice - e Ylie Funeral Home P.A. Gilmor Approximate
Interval Between
Onset and Death 236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to (or as a nonsequence of). Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? 1 □ Yes 2 □ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗌 No 3 Probably 4 Inknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣No 24a. Was an autopsy 2 100 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

after death Director: on 24 hours the Funeral Directory filled in by within 24 hou

To the Fune

completely fi

> State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a, Certifier

1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17 Per FH G893ta7e/88/May Land / Department of Health and Mental Hygiene

			1 - State Registrar	oxiale of Mai	C	ertificate of	Death		9.No.2	21699
	DI		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	Day Year	3. Time of Death
н	Physicia /Medic		SHIRLEY	Н	F]	SHER			04 2009	PM M
-	Examin		4a. Facility Name (If not institution, giv				r Location of Death	0	4c. County of Death	
100			LEVINDALE HEBRE			BALTIN	MORE Tif Under 24 Hrs. T	O Date of Pinth	O Riet	N/A
ı	Funeral Director		203-12-0107	ex 7. Age ☐ M 2 💢 F	(In yrs. last birthda 83 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/24/)	Year) 1925	nplace (State or Foreign untry) PA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	/aryti	ō		LTIMORE	PIKESVI	HE				1 □Yes 2 📉 No
	the l	rec	10e. Street and Number	ETTIONE	TINEOTI	10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or	Funeral Director	ONE SLADE AVENU	E, APT #509	5		21208			USA
	deatl	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 1	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be profilled at	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🗖 No If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:	,	0 "	WHITE
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(G.	cedent's Usual Occu	during most of working		6b. Kind of Business/I	ndustry
121	ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) I	e. DO NOT use retire)MEMAKER	ed)		OWN HOME	
	filed with Hygiene other thai		17. Father's Name (First, Middle, Last,	<u></u>	110	ATELIA (NEIX	18. Mother's Name	(First, Middle, Mi		
Maryland	2 should be fil and Mental H is marked ott aumatic ever	Be	OSCAR	Harter	FISH	:n	EVA	(,		ANKEL
Z	hould nd Me mark matic	ို	19a. Informant's Name/Relationship (Type Print)				al Route Number.	City or Town, State, Z	
Ma	nd 2 sulth ar		ROBERT FISHER /							, MD 21208
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other pla	, ,		0c. Location - City or	
Ë	Pages nent of hant; if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		HAR SIN	,		7/2009 0	OWINGS MIL	LS, MD
Baltimore,	in it	1	21. Signature of Funeral Service Licer			22. Name and Addre	ess of Facility SO	LEVINS	ON & BROS.	, INC.
m	any any	K 10	most Ce			8900 REIS	TERSTOWN	ROAD - P	IKESVILLE,	MD 21208
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line			19			Approximate Interval Between Onset and Death
-5-	Physician		Immediate Cause (Final disease or condition resulting in death)	au	le ply	vasdie	Lup	1ch or	~	2 5 men
1	/Medical Examiner			7/0001/1						
	LAGIIIIICI	<u>_</u>	Sequentially list conditions,	b. Due to (or as a	consequence of):	thery	cuse			10110101
V	nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duc 10 (01 us u	consequence on.					
4	execu n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760,	icate be executed physician and the burial-transit			d						
	rtifica ng ph as th	l edical	E							
Вох	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ☐ Ectopic pregnan	cy		23d. Date of del	ivery Day Year
	e dea the at red fo	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify)	<u> </u>		Month	Day
P.0	d by tetach	Phy	9 Unknown Part II. Other significant conditions	contributing to death but	not resulting in th	underlying cause di	ven in Part I	23e. Did tob	acco use contribute to	the cause of death?
Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burai-transit	d by	Partili. Other significant conditions	contributing to death but	Thorresulting III III	s andonying sause gi	TOTAL COLOR	1 □ Ye	s 2 □ No 3 □ Pi	robably 4 hknown
20.	w requir s been si should b	Completed						24a. Was an	24b. Were au	utopsy findings available
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Vital	ician: Th certificate ector, pag		25. Was case referred to medical				26. Place of Deat		MaNo 1 ☐ Yes	2 □ No
>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Appatier	nt 2 ER/Outpa	tient 3 DOA Ot			nce 6 ☐ Other (Spe	ecify)
of of	ding Physician: The h. After this certificate h funeral director, page	Ë	27. Manner of Death	28a. Date of Injur (Month, Day,	y 28b. Tim	e of 28c. Inju		28d. Describe ho		
jo	Attending or death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	n l	"Journ]Yes 2□No			
Division	I or Attendi after death. Director: A	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
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/	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best o miner: On the basis of and manner stat	examination and/o	eath occurred at the r investigation, in my	time, date and place, opinion, death occur	red at the time, da	ause(s) and manner a ate and place, and du	e to the cause(s)
0	o the ithin (o the omple	Mec	29b. Signature and title of certifier	and manner stat		29c. Licer	nse number	29	9d. Date signed (Moni	th, Day, Year)
	FSFÖ		> Allremi	nes		14	4817		July Ul	12009
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	pe, Print)			July UL Balkyo	1 2009
			Sunit less	un pro	. 243	4 N Bel	nedere	aure	isalhimo	Level 21213
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	4.1				
	Registi	rar	1111 0 2 2009	Chreek	D. Dal	/Car				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2:Date of Death **Physician** Month Dav NYLYY 2130 (1000 al 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4 Glenshire Court Owings Mills Inder 1 Year | If Under Baltimore 8. Date of Birth (Month, Day, 8-26-1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√□ F 128-46-8282 78 Director Jamaica Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 Glenshire Court 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Janaican 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Licensed Day Care Provider Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Princess MacLeish Levi E. Berth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joscelyn A. Goodall/Husband 4 Glenshire Court, Owings Mills, Md 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 7-10-09 Woodlawn, MD 22. Name and Address of Facilin Wylie Functal Home F.A. of Baltimore Co. Woodlawn Cemetery 21. Sign ... e of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 | Yes 2 | No 3 | Probably 4 | Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 **2** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No 1 Yes Certification: To 2 | ER/Outpatient 3∏ DOA 5 Residence 6 □Other (Specify) this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours aft le Funeral DI letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause 31. Date filed (Month, Day, Year) State JUL 0 8 2009

DHMH 17 Rev 1/2001

Registrar

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			for State Registrar	State of M	aryland		rtificate of			•	gien Reg. N	21119	21	701
	Physicia		Decedent's Name (First, Middle JUNE ANN GET)							2. Date of De Month JULY		200 ⁹ 200	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution NATIONAL INST	on, give street and number	EALTH		4b. City, Town, o	SDA				c. County of Death	RY	
l.	Funeral Director		5. Social Security Number 310-40-8473	6. Sex 7. A 1 ☐ M 2 🔀 F	ge (In yrs. la	8 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 10/02/	th ay, Year 1940	r) 9. Birti	place (State intry) IN	or Foreign
	laryland show	or	Usual Residence of Decedent 10a. State 10b. County	,		, Town or Lo	cation						10d. Inside 0	City Limits
	the M 28a-f	Director	TN David	lson	Nash	ville	10f. Zip Code				10g. C	Citizen of What Co		
	h with		1241 Vintage F	PL.			37215				US	SA		
36	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, i'm Mardial Erziniher must be neithed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	12. Was Decedent Armed Forces' rried 1 □ Yes 2 ☑ If Yes Give	? [No		Was Decedent of H f Yes, specify Cub I □Yes 2⊠No			cify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify: Whi	etc.	
Maryland 21215-0036	thin 72 hou ie. an "natura	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	I	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire	during mos d)	st of workin	g		Kind of Business/I		
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ano		Be C	17. Father's Name (First, Middle	, Last)					iers name Lan Ev	(First, Middle	, ivialide	en Surname)		
ary	d 2 should be th and Menta 7 is marked traumatic ev	2	Jerry Kirk 19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street				er, City	or Town, State, Z	ip Code)	
	s 1 and 2 of Health of item 27 is other tra		Daniel Geddie/	Husband		1	Vintage							
Baltimore,	tges 1 mt of H : If iter		20a. Method of Disposition 1 Burial 2 Cremation		,		sition (Name of natory or other place	i		ate		Location - City or 1		
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	Physician /Medical Examiner		23a. Pat/1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. ue to (or as	ine. mow s a conseque fai U	ence of):	er the mode of dyi	ng, such as	s cardiac o	r respiratory a	arrest,		Approxima Interval Be Onset and T do	ate of tween I Death augs
28/60,	ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
	w requires that the death certific s been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3] Ectopic pregnanc] Other <i>(specify)</i> _	су				23d. Date of deli Month	very Day	Year
ecords, P	quires that n signed b uld be deta		Part II. Other significant condit	3 I	but not resul		nderlying cause giv	ven in Part	1. 5 	23e. Did		o use contribute to 2 【▼No 3 ☐ Pr	the cause of obably 4□	
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on or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	မ	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	28a. Date of In	ury	ER/Outpatier 28b. Time of Injury	Wor	ry at	2	ne 5 Resi		6 Other (Specury occurred	cify)	
DIVISION	tal or Atters after destal Directored in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 20e. Place of Ir	ijury - At hor tc. <i>(Specify</i>	me, farm, stro	eet, factory, office		2	8f. Location (City or To	(Street a	and Number or Ru te)	ral Route Nu	mber,
)	he Hospi in 24 hou he Funer pletely fill	ledical		ing Physician: To the bes I Examiner: On the basis and manners	of examinati									(s)
	Voith voith	Ž	29b. Signature and title of certify	er			29c. Licens		(D)		29d. E	Date signed (Month	, Day, Year)	
			20 Name and address of action	MD MD	doath //ta-	220) /Ti	D662	39 M	ÍD		U	7/00/20	7	
			30. Name and address of person ALEXANDRA		ueain (item	دعم) (Type,		ITER I	ORIVE.	, ВЕТНЕ	ESDA	, MARYLA	ND 208	392
	Sta Registra		31. Date filed (Month, Day, Year) 32. Regist	trar's Signati	bar V								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 5:30P 2009 -raction /Medical 4b, City, Town, or Location of Death 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Hones Hospita 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Year) Months Days Hours Min 1□ M 2 🕶 F 212-02-198 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Even in the to retified at 1 Yes 2 No Funeral Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with Dennison VSA 21229 601 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married African Maryland 21215-0036 1 ☐Yes 2 ☑No þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be rank other traumatic ပ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Street I-raction-Mother Dennison 27 Pages 1 and timore Department of Heal Important: If item 2 any injury or other once. Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07-06-09 4 ☐ Donation 5 ☐ Other (Specify) 410n ylie Funeral 21. Signature & Euro 22. Name and Address of Facility Home P.A. Approximate
Interval Between
Onset and Death
OFFARS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease, Immediate Cause (Final disease or condition resulting in death) Metastatic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) To the Funeral Director; After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 X No 3 Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.X.No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in any original death occurred. within 24 hours To the Funeral 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number Signature DO0194

State Registrar

DHMH 17 Rev 1/2001

Avenue

Baltimore MD 21229

th (Item 23a) (Type, Print)

Registrar's Signature

900 Caton

09-04951 Stanley P. Henry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anley P. Henry	1- For State Certif	ment of Health and Mental H	ygiene Reg. No. 2009 2170
Physician/ ledical Examine		Henry	2. Date of Death Month Day Year June 23, 2009 3. Time of Death 1030 hrs
	Facility Name (if not institution, give street and number) St. Agnes Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 1 X M 2 F 67	birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d, Inside City Limits
. .	MD N/A	Baltimore	1 X Yes 2 No
h the Maryland 3a or 28a-f sh lotified at once	2424 Christian Street	10f. Zip Code 21223	10g. Citizen of What Country? USA
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "ostural", or items 23a or 28a-fabe traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
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21215-0036 21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica TO Be Comple	17. Father's Name (First, Middle, Last) Paramanayagam Henry	18.Mother's Name Push	(First, Middle, Maiden Surname)
MD 2121 d 2 should be fi lth and Mental I n 27 is marked n marke To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crem	2424 Christian Street De of Disposition (Name of cemetery, matory or other place)	Baltimore MD 21223 Date 20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite Important: If ite Important of the Information of the Informati	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee George MacNab	Shepherd Cemetery 7/b 22. Name and Address of Facility Mag	9/09 Ellicott City, MD
M N N N N N N N N N N N N N N N N N N N	23a. Part I. Enter the disease, or complications that caused the death. Do	301 Frederick Ro	ad Catonsville. MD 21228
Medical laminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclero		Between Onset and Death
5	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):		
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
60, In the executed hysician and eburial - transit	d d		
68760, certificate be execunding physician and sa the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnan		23d. Date of delivery
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	ncy Month Day Year
by deta	Part II. Other significant conditions contributing to death but not result	lting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown
of Vital Records, Ig Physician: The law requires Ther this certificate has been signeral director, page 2 should be 1: To Be Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
tal Recidina: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2 No 1 Yes 2 No
of Vit ing Physic After this cuneral dire	27. Manner of Death 28a. Date of Injury 28	DOA Other Nursin	g Home 5 Residence 6 Other: 28d. Describe how injury occurred
C# 1 2 2 0	1 Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division o spital or Attending hours after death. ocral Director: Aft filled in by the fune Certification:	4 Homicide Could not be determined (Specify)	, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attent within 24 hours after death To the Fuoeral Director Completely filled in by the	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/one) and manner stated.		
Ž	29b. Signature and title of certifier ARROR HOLDEN	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 1, 2009
	30. Name and address of person who completed cause of death (Item 23: Carol Allan, MD Assistant Medical Examiner 11	a) 1 Penn Street, Baltimore, MD 2120	1
State		barles	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 07-02-2009 330 A M Robert G. Hippensteel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Be 1 Air 508 Plumtree Rd Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 ☐ F 06-30-1921 PA 88 201-16-1500 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Evantical must be multified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 21 No Director Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21015 508 Plumtree Rd Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White ⋛ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) APG Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Goodhart Robert H. Hippensteel ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, MD 21015 508 PlumTree Rd Mary E. Hippensteel (Wife) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-03-2009 | Baltimore, MD Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Emersi Service Li Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. -04 ONARY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquestivally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 1 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ 106 24a. Was an cate has by page 2 s autopsy performe certificate 2 No 1 □Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after deau..

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) of certifier 29c. License number 29b. Signature and n (6444

State Registrar 31. Date filed (Month

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. NAIR

08

602. S. ATWOOD Rd. Belain. MD 21094

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** HARTSEL LOUIS HUGGINS 2009 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANHE SALTIMORE IX ASITINGTON MEDICHL CENTS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 3/13/1930 ar) 1X M 2□ F 79 S.C. 250-38-9450 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c, City, Town or Location 10a State show Department of Health and Mental Hygiene important; if item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedford Exercities on the motified at once. MD 1 ☐ Yes 2X No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 USA 923 Princeton Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Huggins, Hart Se Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1∐Yes 2XNo Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Welding Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be (Unknown) Lelia Roger Huggins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs Margaret Huggins/wife 923 Princeton Terrace Glen Burnie MD 21060 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/6/2009 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home M01364 Glen Burnie MD 21061 421 Crain Hwy SE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner MENTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown g 🖂 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 3 Probably 4 ■ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be frector, page 2 st autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours after le Funeral Dire bletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

the

Registrar

29b. Signature and title of certifier

APS A

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

2. Registral's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Molica Alicia Hazell-Hurley 10.17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehabilitation and Nursing Center Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 12, 19 9. Birthplace (State or Foreign Country)
St. Vincent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 084-74-2109 42 1966 St. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 4111 Weller Road United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black. δ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government the 2 should be filed w and Mental Hygier Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Wilbert Hazell Ina Mona Kydd 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau David Oneal Hurley / Husband 4111 Weller Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 11. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 ☐Removal from State Gate Of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral survice Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Christelle M01305 mario 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): burial-1 Box 68760, attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1□ Yes 2☒ No 3 ☐ Ectopic pregnancy Por Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I by the 9☐Unknown 9 Unknown signed I Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page certificate Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation (Month, Day Year) Natural 2 Accident 1 Yes 2 No death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

To the Funeral Director: After completely filled in by the funer. To the Hospital hours within 24

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Streelin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

128595

29d. Date signed (Month, Day, Year)

Somith Art, SUITE 203 BALLO MD 2122P

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** :13 JULY 4. 2009 JACK HAYWOOD JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A LONG GREEN NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days MARYLAND 10-14-1940 68 Director 217-38-0106 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County 28a-f shov r items 23a or 28a-f shov 1X Yes 2 □ No Director MD. N/ABALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 1720 McKEAN AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or or other traumatic event, the Wedler Exert 1 ∐Yes 2 🕅 No Specify Specify: BLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -9-LABORER LAUNDRY -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACK HAYWOOD SR. ALINE PORTER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOUISE BROGDON(SISTER) 1720 McKEAN AVE. BALTIMORE, MARYLAND 21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or once. 5 ☐ Other (Specify) MT. ZION CEMETERY 7-9-2009 BALTIMORE, MARYLAND ral Service D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme: te Cause (Final disea or condition resulting in death) METASTATIC **Physician** COLON YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a conse wence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician a the burial Division of Vital Records, P.O. Box 68760, attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 2 No 1 Tyes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide i 24 hours after e Funeral Dire letely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor

To the Fune

completely fi (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an 031136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD, BALTIMORE, MID 21236 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:05AM Keith Theodore Johnson 2009 26, June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Future Care /Homewood Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₩ M 2□ F Yrs 28, 1955 Maryland Director 54 214-68-3393 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evantment rust be notified at any injury or other traumatic event, If a Medical Evantment rust be notified at appne. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Baltimore Maryland N/A10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3rd floor 21217 USA 1715 Gwynns Falls Parkway

11. Marital Status

MXNever Married 2 Married
3 Widowed 4 Divorced

171. Was Decedent Ever in U.S. Armed Forces?
1 See 2 No If Yes, Give Year or Dates: Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital Maintenance Worker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Estep Jean H. Johnson ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise T. Johnson/ Sister 4247 Nadine Srive Baltimore, Maryland 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery
22. Name and Address of Facility Dundalk, Maryland 21. Signature of Fuser | Service | Service | Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 aux 23a Fart 1 __nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s __ok, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 □Yes Be 25. Was case referred edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my kn ledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examiner in the basis of examiner in the cause(s) and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name of d address of person who/completed cause of death (Imm 21a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

West

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan					ntal Hyg	iene		01700
			State Registrar		Се	ertificate of	Death			eg. No. 2	19	21709
	Physici	an	1. Decedent's Name (First, Middle, Las	•					Date of Deat Month July	5, 2ď	205	3. Time of Death 10:19 AM
	/Medic		Evelyn Agnes Jo 4a. Facility Name (If not institution, give			4b. City, Town,	or Location		July	4c. County of I		10.17
	Examir	ier	Stella Maris Ho			Timon		of Death			timor	re
	Funeral	0	5. Social Security Number 6. S	L	last birthday	/) If Under 1 Year	If Under		Date of Birth (Month, Day,	(Voor) 9.	Birthplac	e (State or Foreign
	Director		212-03-6431	□м 2ХД F	97 Yrs.	Months Days	Hours	Min. F	eb 8,	1912	Maryl	and
~	P.		Usual Residence of Decedent	7.0							104	Inside City Limits
8	arylar show	_	10a. State 10b. County		y, Town or L							1 ☐ Yes 2√ No
5	ne Ma 18a-f	Director	Maryland Baltin	nore	Glen					O- Older of Miles		
2	Vith th	ä	10e. Street and Number			10f. Zip Code	1057		'	0g. Citizen of What USA	at Country	f
10:19 gm	death with the Maryland ims 23a or 28a-f show	Funeral	1 Gun Powder Road	12. Was Decedent Ever in U.	S 12			rigin? (Specif	v Yes or No-	14. Race -	American	Indian.
	item	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	0. 10	. Was Decedent of If Yes, specify Cub		ın, Puerto Ric	can, etc.)		White, etc.	
336	irs af		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify	<i>'</i> :		Specify:	Whit	e
2009 21215-0036	2 hou	Completed by	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dec	edent's Usual Occu	pation	st of working		16b. Kind of Busin	ess/Indus	try
0 2	thin 7 ne. nan "r	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire	ed)	· ·		Talankan.	o Com	nont.
25 25	ed wi		12		Tere	ephone Op				Telephone Maiden Surname)	e Coli	ірапу
Maryland	be fil	Be	17. Father's Name (First, Middle, Last) Frederick Bruhl					Susan		vialuen Sumame)		
7/ <u>5</u>	d Me mark	우	19a. Informant's Name/Relationship (10h Mai	ling Address (Stree				r City or Town St	ate Zin Ci	nde)
→ B	d 2 s Ith an 17 is t		Barbara Gibbons		1	Gun Powd						
7 ē.	Heal Heal tem 2	1 8	20a. Method of Disposition			position (Name of ematory or other pla		Date		20c. Location - Cit		
7 0	Pages ent of nt; If i		1 ☐ Burial 2 [XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)	Removal from State		ematory or other pile cematory	_ i	07/06	/09	Baltime	ore.	Maryland
$\int \mathcal{U}_{\mathcal{L}}$ Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It., M. digni Ever, inc. in 1910. In Julia a once.		21. Signature of Funeral Service Licen									
ñ	permii Depar Impor any In	1	Jamas S	Sugar		22. Name and Addr Cremation 299 Frede	rick	Road B	altimo	re, Mary	land	21228
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that caused the death	h. Do not e	nter the mode of dy	ring, such a	s cardiac or r	espiratory arr	rest,	A	pproximate terval Between
	Physician	8 6	Immediate Cause (Final disease or condition	METASTATI	10 C	PANCER	, Us	KROU	NN 7	RIMARY	/ 0	nset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):		/ //	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Examiner	اپ	Sequentially list conditions,	b							-	
1.1	bet ted	Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence ot):							
6	execur and	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):							
\$760,	icate be executed physician and the burial-transit	dical		d								
111 0	tificat ig phy as the	ledi										
Nox Nox	death certif e attending d for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		B ☐ Ectopic pregnar	ncv			23d. Date of		Vaas
10 -	e deal	Sicie	in the past 12 months? 1 ☐ Yes 2 ANo	4 ☐ Pregnant at time of c		Other (specify)				Month	n Da	ay Year
1 of 0.	nat the d by t etach	Physician/Me	9 Unknown	ontribution to dooth but not roo	ulting in the	underlying course of	ivon in Port		23e Did to	bacco use contribu	ute to the	cause of death?
, Sb	e law requires that the death certif has been signed by the attending e 2 should be detached for use as	٥	ran ii. Other significant conditions o	onlineding to death but not resi	ultilig in the	underlying cause g	Iveninran	. 1.	1 □ Y	W		ly 4 ☐ Unknown
2 6	requ been should	etec							24a. Was a		ro autono	y findings available
VItal Record	The law ate has b page 2 sh	Completed							autop:	sy prid med? dea	or to comp ath?	letion of cause of
17 E	ificate		25. Was case referred to medical				26 Diag	o of Dooth /	1 □ Yes Check only or		Yes 2	UNo
	Physician: this certific	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpati	ient 3 DOA O	thor:		5 🗆 Resid	10	(Specify	OSPICE
A P	ding Physician: The I h. After this certificate hi funeral director, page	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	of 28c. Inj				ow injury occurred		
ior	tending leath. tor: After the funer	atio	1 Natural 5 ☐ Pending 2 Accident investigation	1	,,		∃Yes 2[□No				
Division	or Att after de Directo in by t	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, s fy)	street, factory, office)	28	f. Location (S City or Tow	treet and Number n, State)	or Rural F	Route Number,
۵	Hospital c 24 hours af Funeral D stely filled is	Ce	29a. Certifier 1 ☐ Certifying Pt	ysician: To the best of my kno	wledge de	ath occurred at the	time data	and place or	nd due to the	cause(s) and man	ner as stat	red.
J_i	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ation and/or	investigation, in my	opinion, de	eath occurred	at the time,	date and place, an	d due to th	ne cause(s)
И	To the vithin 2 To the comple	Me	29b. Signature and title of certifier			29c. Licei	nse number		2	29d. Date signed (Month, Da	y, Year)
			1 State	ent		K14	9792	2		116	2009	
	•		30. Name and address of person who	completed cause of death (Item	n 23a) (Type	e, Print)	10	1.1	ANALL	11 45	71	OG2
			31. Date filed (Month, Day, Year)	NT LSUU III 32 Registrar's Signa	LANE ature	y valle	7 161	1 1/	70/4/14	14, 1-(1)	4	UD
	Sta Regist	ate rar	III no non		1 1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jul 2, 2009 Paul Johnson, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Raltimore 17 King James Circle 185 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 ☐ M 2 ☐ F Director Sep 26, 1949 219-52-3370 Usual Residence of Decedent 2005 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be notified at Director **Baltimore** Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 U.S.A. 17 King James Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: 3 3 Widowed 4 Divorced Completed ٢ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Self Employed College (1-4or 5+) Disabled Johnson 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Eskridge Paul Johnson Sr. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 17 King James Circle Baltimore, Maryland 21207 Shunda Johnson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Paul 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/07/09 Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 21. Signalu of Funeral Syrvice lic-18 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician erioscleratu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transi and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No ρ 5 ☐ Other (specify) cate has been signed by the page 2 should be detached o 9 Linknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has

Division of Vital Records, lospital or Attending P 4 hours after death. uneral Director: After t

> State Registrar

funeral director,

filled in by the

this

After

24 hours a Hospital

within 2

Be

Certification: To

Medical

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 ☑ No

examiner?

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

31. Date filed

4 Homicide

(Check only one)

29b, Signature and title of certifie

Month, Day, Year,

1 🗀 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

29d. Date signed (Month, Day, Year)

perform 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

3. Time of Death

М

1852

Maryland

Black

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 Yes 2 □ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

1 Vimb

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Thomas Aloysius Jock1e 2009 2:00a July /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville Fairhaven If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days Months Hours 1 GM 2 □ F Yrs. Director 096-20-5504 80 Sept 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Sykesville MD Carroll 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7200 Third Avenue by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Korea than "natural", or Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) insurance underwriter insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any lipiny or other traumatic event once. Margaret E. Ludwig Phillip Edward Jockle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Liberty Ridge Ct., Owings Mills, MD 21117 Glenn A. Jockle (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 7-3-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Day Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner inan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit anolexia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ta months attending p for use as t IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has page 2 2 No 1 □ Yes uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1_Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg 1645 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17.18 per fh g893 7-8-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** E. Helen Kaufman %q00:8 6, July /Medical 4a. Facility Name (If not institution, give street and number)
Sunrise Assisted Living 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/21/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 XF 90 171-14-8566 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show MD Howard Columbia 1 XIYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 6500 USA Freetown Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ò Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Engel Albert A. Engel Alberta A. -Philamina Cecelia Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kaufman Castle Hill Ct., Ellicott City, MD 21042 Gary 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Assumption Cemetery 7 M Glenshaw, PA
of St. Marys
Sphall

22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230

Approximate
Approximate
Approximate
Approximate 7/11/09hh 1 Neurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 3 years Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify). 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **6** Type II Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ X No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

| Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. July 7, 2009 D 56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harry Li, M.D. 8600 Snowden River Parkway, # 301, Columbia, MD 21045 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001 30. Name and

31. Date filed (Month, Day, Year)

JUL 0 8 2009

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

WESTMINSTER LAD 2115

Yess Oberson who completed cause of death (Item 23a) (Type, Print)

CONTER ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29 2009 1:55 A Casimer C. Legal Jr. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5400 Vantage Point Road Columbia Howard Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months 176-10-5580 FEB 3, 1915 **Director** <u>Pennsylvania</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐Yes 2 X No Director Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5400 Vantage Point Road 21144 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ... within ... wental Hygiene... 27 is marked other than "r traumatic ever" Elementary/Secondary (0-12) College (1-4or 5+) Chemist Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casimer C. Legal, Sr. Beulah Snyder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15615 Bushy Park Road Department of Health Important: If item 27 any injury or other tonce. Janet E. Reedy, daughter Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 07/02/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. E-11/2 299 Frederick Road Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit physician s the burial Division of Vital Records, P.O. Box 68760, attending pl signed by the a s certificate has b irector, page 2 s this certific al director, Director; d in by the n 24 hours after he Funeral Dire bletely filled in b

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.

t of Health a

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Certification: To

2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

∂b.	Signatu	re	and	title	of	certifier	<
	. .	Pa.				0	

29c. License number

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print)

State Registrar

completely

within 2 To the F the

Medical

29a. Certifier

Day, Year) 08

Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

	-	Please Type or Print State of Ma		Depa		ealth and N	lental Hyg	iene	ible.	21716
Physicia		State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	inicate of L	Jean	2. Date of Death	Day	Year 2009	3. Time of Death
/Medic Examin		Hope Elizabeth Lorden 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical	Cente	To a	4b. City, Town, or	Location of Death		4c. Count	y of Death	imore
Funeral Director		5. Social Security Number 6. Sex 7. Age none 1 □ M 2 ☒ F	(In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	Hours 24 Hrs.	8. Date of Birth Month, Day July 1,2	009	9. Birthpla Count Ma1	ace (State or Foreign ry) 1 y land
ryland i how			10c. City, Tow						10	d. Inside City Limits Y Yes 2 □ No
th the Ma or 28a-f s a notified	Directo	Md . 10e. Street and Number		Bal	timore 10f. Zip Code		10	0g. Citizen of	What Count	
rs a	by Fu	1433 Haubert Street 11. Marital Status 1 Never Married 2 Married 1 Pres 2 Divers 1 Pres 2			Was Decedent of Hi f Yes, specify Cuba	230 ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ick, White, e fy: Wh	
hin 72 ho 9. an "natur Medicul	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+		Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work)	ing	16b. Kind of E		ustry
filed with Hygiene other the ent, the	Be Con	0 17. Father's Name (First, Middle, Last)				infant 18. Mother's Nam	e (First, Middle, M		nfant me)	
ould be I Menta narked natic ev	To B	Raymond C. Lorden III					yn Ah			0.71
nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) Raymond C.Lorden III	19		ng Address <i>(Street a</i> 1433 Haub			o. Md.		
Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter Holy		sition (Name of natory or other place	1	8,2009	20c. Location		
permit. Departn Importa any Inju once.		21. Signature of Funeral Service Licensee	,	22	2. Name and Addres		nimunek	Funera	1 Home	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) EXTREMODIAN Due to (or as a	e. 1E PRE	:MAT	er the mode of dyin					Approximate Interval Between Onset and Death
eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a Due to (or as a d								
The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the I	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of the past 12 months? 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		☐ Ectopic pregnanc	у			ate of delive	ry Day Year
e law requires that the di has been signed by the e 2 should be detached	þ	Part II. Other significant conditions contributing to death bu SEVERE PREECLAMPSIA (not resulting			en in Part I.	23e. Did tol	32"	ntribute to th 3 ☐ Prob	e cause of death? ably 4 ☐ Unknown
	Completed	NEPHROTIC SYNDROME (M	IATERN	AL)			24a. Was a autops perform	sy	prior to cor death?	osy findings available npletion of cause of 2 No
Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatie	nt 2 □ EB/C	Outpatie	nt 3 □ DOA Oth	26. Place of Dea er: 4 □ Nursing H	th <i>(Check only on</i> ome 5 ☐ Reside		ther (Snecifi	<i>(</i>)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day investigation	ry 28b.	Time o Injury	f 28c. Injur Work		28d. Describe ho			
tal or Atters al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, f c. (Specify)	farm, str	reet, factory, office		28f. Location (Si City or Town		nber or Rura	l Route Number,
he Hospit in 24 hour he Funera pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination a	ge, deat and/or ir	h occurred at the til nvestigation, in my c	me, date and place opinion, death occu	rred at the time, o	date and place	e, and due to	the cause(s)
To the within To the company	Ž	29b. Signature and title of certifier Minham 94. Agenm	ott n	0	29c. Licens	e number 127352	2	29d. Date sign	ned (Month,	Day, Year)
		30. Name and address of person who completed cause of de	eath (Item 23a		Print)	VE TOW	SON. MAI	RYLANI	212	2 34
Sta Registr		31. Date filed (Month, Day, Year) 32. Registra JUL 0 8 2009	ar's Signature	Park	2					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Charles Edward Litz Jr. **Physician** 3:15 PM 2009 July 1 /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) 12-6-1923 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Hours Min. Months Days 1X M 2 □ F 85 Maryland 218-18-0978 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Exemples must be notified at MD Reisterstown 1 □Yes 2X No Baltimore Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 300 Salony Drive 21136 death \ by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itemany Injury or other traumatic event "". 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ∐Yes 212 No Specify 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Photographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Litz Sr. Marguerite Yockel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Edward Litz-son 12 Fox Meadow Garth Westminster, MD 21157 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens 7-6-2009 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Euneral Service Lices Komas 254 E. Main St., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Buns

29b. Signature and time of contifier

COURS HARAM

29c. License number

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Month 009 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death AMARITAN -71MO BA If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🔀 F 212-34-1809 01/18/1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 601 Joppa Farm Road 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 2**X**MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes XXNo Specify: Specify: White 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Technician Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Walden Frederick Herbert Blake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 601 Joppa Farm Road, Joppa, Maryland 21085 Diane McNamara (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Bayview Crematory, Inc. 07/09/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ski Funeral Home, P.A. 21. Signature of Funeral Service Licer 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1- Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immedi Cause (Final disea or condition resuring in death) CONGES Due to (or as a consequence of): TROINTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) □Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner certificate be executed burial-trar Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Trans Andreal Evatainer, ust be not the day

filed within 72 hours after of Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, it.

3altimore, Maryland 21215-0036

Examine attending physician Physician/Medical as the ase for t the ģ ģ Completed Certification: To

Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 TWO

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examîner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

1 ANatural
2 Accident

3 Suicide

29c. License number D0058913 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 WHRAVEN BOYLEVAR!

MAN 15HA BAHL

BALTIMORE, MARYLAND R123

31. Date filed (Month, Day, Year)

32. Begistrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

Marrion



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nd. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** Margery Lehman /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE YMME MEDICAL HTIMORE ENTE Birthplace (State or Country) 7. Age (In yrs. last birthday) Year | If Under 2 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Director 96 March 2 1913 Pennsylvania 578-05-3992 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10h. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland A.A.Co. Pasadena Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 478 Center St Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Marylan'd 21215-0036 1 ☐ Yes 2 ☑ No Specify. white If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Household Homemaker item 27 Is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ludwick Louis Emma Heness ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margery Pohlner daughter 478 Center St. Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Carmel U.M. Cem. 7/11/09 Pasadena Maryland 4 Donation 5 Dother (Specify) 21. Signatura of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the diseashock, or heart failure Approximate Interval Between Onset and Death se, or complications the List only one cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events Dise to (or es a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear 1 □Yes 2 □ No. certificate has been signed by the rector, page 2 should be detached 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed∕ 1 □Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural hours after death. uneral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who o

and B. Jank

empleted cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** Ross Hascue Lawson 1:10pm Ju1y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year, 6 Sex 7. Age (In yrs. last birthday) **Funeral** X M 2 □ F Months Days Hours Min 1926 408-36-0930 82 July 15, **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov other than "natural", or items 23a or 28a-f showent, it a fredical Example or must be notified at 1 □Yes 2 No Director Carrol1 Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 705 Scotsdale Road 21157 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, If a findian Exp. in activust any Injury or other traumatic event, If a findian Exp. in activust any Once. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

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ff Yes, Give
Year or Dates: WWI. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 👿 No Specify Specify: White ģ WWII 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contracting Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Ruth Lawson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Bernice Lawson (Spouse) 705 Scotsdale Road, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 7/6/2009 Sykesville, MD 21. Signature of Funeral Service License P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each J Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pt for use as th IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No sbeen signed by the should be detached 9 Unknown 9 Unknower 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an has e 2 s autopsy ar this certificate has eral director, page 2 1 □Yes 2 No 25. Was case referre medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address

31. Date filed (Month, Day, Year)

555 CENTER ST WESTMINSTER, MD21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Darlene L. Mackey 24, 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/AJohns Hopkins Bayview Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F 51 214-72-8571 14,1958 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Baltimore Dundalk 1 ☐ Yes 2€No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 116 Calvin Hill Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes **XX**No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event. Its incompany or other traumatic event. Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Security 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glossie Parker James Gilmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Calvin Hill Ct. Dundalk, MD 21222 James Mackey/ Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State Mt. Carmel Cemetery 7/2/09 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 4210 Belair Road Baltimore, MD 21206 corr 23a. Part I-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hymer Lturioc Immediate Cause (Final Carriovascular ds. **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if a m, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jun to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed lours after death. reral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burla-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? Hypothyvoid 24a. Was an 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records, 24 hours a the Hospital the

1 Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D28266. 30109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5010. YURK ROEN, Ballete, MD 21212 AyELWIN. M.D.

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 55 Victoria Piazza Manna 2009 /Medical am 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Levindale Nursing Home Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗓 F 213-32-2895 96 Director 04-20-1913 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Harford Forest Hill 1 ☐ Yes 2X No Directo 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? ŏ 23a 1912 Jean Court 21050 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married P. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3X Widowed 4 □ Divorced natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) Secretary NY Board of Education Department of Health and Mental Hygis important: If item 27 is marked other any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Peter Piazza Maria Piazza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Corum (Daughter) 101 Thistledown Ct Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Lorraine Park 07-08-2009 permit. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or com shock, or heart failure. List only , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Smin /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nama icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Inknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate I 2□ No 1□ Yes 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 dursing Home 5 Residence 6 Other (Specify) After this 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours and
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----←elv filled ir the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chedere ane 2434 31. Date filed (Month, Day, Year) State Registrar

	-	For State Registrar	State of Maryland		rtment of F <i>tificate of l</i>			giene Reg. No. 2	109	21723
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F š F o		30. Name and address of person who	completed cause of death (Item		Print)	064732		07		2009 nesda, MI
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<u>S</u>	Attending P r death. sctor: After by the funer													
Division	after death Director: / d in by the		4 Homicide	ad 200. Place	e of Injury ling, etc. (Sp	At home, fa	arm, street, fa	actory, office			Street and Numb wn, State)	er or Rura	Route Number,	
	ital or rei Dir llad in													
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	To the Hospital or Att within 24 hours after of To the Funerei Direct completaly fillad in by	8	one) 29b. Signature and title of certifier	and man	ner stated.			29c. Licens	se number		29d. Date signe	d (Month	Day Yeer)	-
	5. <u>₹</u> 6. <u>9</u>		Pan W	7.41-	10.5						1	109	, a, 100//	
					MD			124	7683		1131	21		\exists
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Ray Month Million Z5 Main Street Street Zoo Reinhorium MD 21136														
		114	31. Dete filed (Month, Day, Year)	25 A	Registrarie C	innature	- JW	re 20.	rent	/PMMV /	.0 2	1 2 10		4
	State Registra		31. Dete filed (Month, Day, Year) JUL 0 8 20	19 Sent	w j	1. 1	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05061 State of Maryland / Department of Health and Mental Hygiene Leonard Marandiuc 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month June 26, 2009 Medical Examiner Leonard P. Marandiuc c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Director Aug. 14, 1971 37 1 X M 2 F Yrs 339-78-6342 Usual Residence of Decedent 10c. City. Town or Location 10b. County 28a-f shov 23a or 28a-f shou Maryland Montgomery Gaithersburg death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9801 Mahogany 20878 . A 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. If Yes, Give Year Yes 2 X No specify: Divorced Widowed Þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Computer Elementary/Secondary (0-12) College (1-4 or 5+) he Medical Information Technology Programmer 5 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dimitrie Marandiuc Paraschi<u>va</u> Gradinaru 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street, Chicago, Illinois 60615 Mihael Hategan 1211 East 52nd 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Chicago, Illinois Bohemian National 7-17-09 Donation 5 Other Specify Cemetery me and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line 'Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed ian/Medical UNPENDED AMENDED physician the burial e Hospitat or Attending Physician: The law requires that the death certificate be each hours after death.

24 hours after death.

Penneral Director: After this certificate has been signed by the attending physicia Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. δ ۵ Completed Records, 24a. Was an autopsy performed? ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Other 4 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA 1 Yes ٩ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural Yes 2 No Division Pending 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 To the I

Between Onset and Death 23d, Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Residence 6 Other 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City 29d. Date signed (Month, Day, Year) 29c. License number June 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature ORIGINAL

1950 hrs

Country

White, etc.

Romania

10d. Inside City Limits

1 Yes 2X No

31. Date filed (Month, Day, Year, State Registrar

29b. Signature and title of certifier

Russell Alexander MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) **Physician** Mack 6:50 A M Kathryn 2009 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dunda1k Genesis Heritage Meridian Ctr. 8. Date of Birth (Month, Day, Year) 09/27/1913 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Maryland 1 □ M 2 🖾 F 95 218-18-5645 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Middle River MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 520 Carrollwood Rd. Apt. B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 📉 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2⊠ No Specify: Specify: ò White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important; if them 27 is marked oth any lighty or other traumatic event once. Be Gerlock Margaret Hager George ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9104 Old Harford Rd. Parkville, Maryland 21234 Jacqueline Jacobs (daughter) Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 07/07/2009 Oak Lawn Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of 21. Since ture of Funeral Service Ligensee Dundalk, MD 21222 Dundalk, Inc. 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Cayentiany list continued in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s performe 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To After this funeral c 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ma MD D 27188 7-3-09

ath (Item 23a) (Type, Print)

Le 2 Market Place D undake neo 21222

State Registrar Date filed (Month, Day,

10

09-05066 Kelly M. Murray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009

		1- For State Registrar	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate	of Deat	h			Reg.	No.		
Physicia	ın/	Decedent's Name (First, Middle,Last)						l N	Date of Death	ay Year	3. Time of Death 1926 hrs	
dical Examin	ner	4a. Facility Name (if not institution, give	ly Michell	e Murray		own or Lo	ocation of D		une 26, 200	4c. County of Dea		
		Connecticut Avenue and Ea		y	Bethe		000000000000000000000000000000000000000			Montgomery	1	
Funeral		Social Security Number 6. Sex	7. Age (I	n yrs. last birthday		er 1 Year	If Under 2	_	Date of Birth(MM/DD/YYYY) 9. E	einn	
Director		575-04-5020	4 2 X F	40	Yrs. Month	s Days	Hours	Min.	pril 3	. 1969	Country) Hawaii	
any		10a. State 10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits	
≱	<u> </u>	Maryland Montgo	merv			Chev	y Cha	ase			1 Yes 2 X No	
Maryland 28a-f show d at once.	Director	10e. Street and Number	<u>,</u>		10f. Zip				10g	. Citizen of What Co	ountry?	
h the 3a or		3909 Lela				20	0815				l States	
th witl ems 2	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	Mas Decede	ent of Hisp fy Cuban,	anic Origin? Mexican, Po	? (Specif uerto Rica	y Yes or No- an, etc.)	14. Race - Am White, etc.	erican Indian, Black,	
er dea		3 Widowed 4 Divorced	1 X Yes 169, f Yes, Give Year 1998	4∾2001	Yes 2	X No	specify:			Specify:	White	
ırs aft tural"	d b	15. Decedent's Education (Specify only	OI Dates.	eted) 16a. Dec	edent's Usual	Occupation	on (Give kin			16b. Kind of Busines		
72 hoi	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)) duri	ng most of wo	rking life. I	DO NOT us	se retired)				
5-0036 led within 7 Hygiene. other than	dm		5+		P	rofes					ersity	
filed v Hygi d oth		17. Father's Name (First, Middle, Last)				1	8.Mother's I	Name (Fii		aiden Surname)		
2121 ould be fi Mental I marked c event,	o Be	Jai 19a. Informant's Name/Relationship (Ty	nes Welter pe, Print)	19b. M	failing Addres	s (Street	and Numbe	er or Rura		Edwards er, City or Town, St	ate, Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Ne ikal Examiner must be notified at once.	-	John Sean Joseph Murra	y/ Husband	39	909 Le1	and	Street	t Che	evv Cha	se. Marv	land 20815	
re, l l and Healt Fitem		20a. Method of Disposition	Removal from State	20b. Place of D		me of cem		D	ate	20c. Location - City	or Town, State	
Pages eent of init: It		4 Donation 5 Other Specify:	Removal from State	of Hea	ven Ce	meter	.v	Ju1	2009	Silver Sp	ring Maryland	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other transmatic event, the Mental Institute.		21. Signature of Funeral Service Licens	11		22 Name an	Address	of Facility R	Rober	t A. P Inc 0814-3	umphrey F	Funeral Home/ sconsin Avenue	
Physician		23a. Part I. Enter the disease or compli	cations that caused th	100335 L ne death. Do not e	nter the mode	of dying,	such as care	diac or re	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
/Medical		failure. List only one cause on each immediate Cause (Final disease a.)	n line. Nultiple Injuries								Death	
aminer			ue to (or as a conseq	uence of):								
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	oue to (or as a conseq	uence of):								
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760, icate be physici the buri	Medical	IF FEMALE:	23c. If yes, outcome		094 0/					23d. Date of deli	•	
687 certific nding p		23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at ti	me of death	Fetal deat		Ectopic	pregnanc	у	Month	Day Year	
Box 687 e death certifithe attending the attending	Physician	1 Yes 2 No 9 V Unknown	9 Unknown	me or death 5	_ Other (Sp	ecity)						
tal Records, P.O. Box 68' rian: The law requires that the death certificate certificate has been signed by the attending ector, page 2 should be detached for use as:		Part II. Other significant conditions	contributing to death	but not resulting in	n the underlyi	ng cause g	iven in Part	t I.			e to the cause of death?	
S, P.	d by										Probably 4 Unknown	
ords w requisited should	plete								24a. Was a	sy prior	e autopsy findings available to completion of cause of	
Recorder The la	E	24a. Was an autopsy performed? 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No										
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should t	Bec	25. Was case referred to medical examiner?	ospital:				of Death (C			Residence 6 🗸 C	2th Conne	
ing Physic After this	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur		ne of Injury	DOA	ry at Work?			now injury occurred	otner: Scene	
on o nding th. : Afte	힖	1 Natural 5 Pending	FOUND: Day, Ye	ar) FOUN	D:		Yes 2 ✔ I	מו			struck by tree branch	
Division tal or Attendir rs after death. al Director: A led in by the fu	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Connecticut Ave & East West Hwy, Bethesda, MD										r Rural Route Number, City	
Divi											Hwy, Bethesda, MD	
Hos 24 h Fillr											stated. to the cause(s)	
To the comple	Med	29b. Signature and title of certifier	and manner stated.			9c. Licens					(Month, Day, Year)	
		D+ O-	don			O.C.	M.E.			June 27, 200	9	
		30. Name and address of person who	completed cause of de	eath (Item 23a)						I	· · · · · · · · · · · · · · · · · · ·	
		Patricia Aronica-Pollak MD		edical Examir	ner 111	Penn St	treet, Bal	Itimore,	, MD 2120	1		
S		31. Date filed (Wonth, Day, Year)	32. Registrar	's Signature	Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Repartment of Health and Mental Hygiene

Priviciant Pri	loane Murray		Amend Item 9 per Th, go	Spannes 405 and Mental Hy Certificate of Death	Reg. No. 2	009 2172
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The state of the s			216-61-2055 Not-Available	Months Days Hours Min.	Fo	
3909 Leland Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent File in U.S. 14. Race - American Indian, Black. White etc. 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Marital Status 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Numb	япу			City, Town or Location		10d. Inside City Limits
3909 Leland Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent File in U.S. 14. Race - American Indian, Black. White etc. 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Informant's Name-Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Marital Status 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Marital Status 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Numb	and show	ا ا	Maryland Montgomery			1 Yes 2 X No
Physician // Medical caminer Approximate Integrated Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Maryl r 28a-f	irect	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
Physician // Medical caminer Approximate Integrated Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	vith the	alD				
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Physician // Medical caminer Approximate Integrated Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Ore, es l an of Hea If iter			crematory or other place)	uly	ty or Town, State
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O sign of the part	VISI or Att after de Direct	tifica	3 Suicide 6 Could not be 28e. Place of Injury		or Town State)	
determined (Specify) Major Road / Highway Connecticut Ave & East West Hwy, Bethesda , MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ospital hours :		4 Homicide (Speak) Wajor		·	
Do by Accident Suicide	thin 24	dical	one) 2 Medical Examiner: On the basis of examina	tion and/or investigation, in my opinion, death occurred	at the time, date and place, and due	e to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (<i>Montal</i> , Day, Fear)	- 5.3 E. 3	₩.				
Patri a - Holler o O.C.M.E. June 27, 2009		:	Patill- tolle.		June 27, 200	ມສ
30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	_		· · · · · · · · · · · · · · · · · · ·		ore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			31. Date filed (Month, Day, Year) 32. Registrar's S	Signatura		

Avery Mattison

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26perPHYS, G893, 7,8,09, WS
State of Maryland / Department of Health and Mental Hygiene | | | | | | | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7, July 2009 3:15 A M Harold Nicolai Nilsen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Talbot Wye Mills 28665 Earthlite Road 9. Birthplace (State or Foreign Country)
Rhode Island If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days Hours Min. | Month, Day, 7. Age (In yrs. last birthday) Social Security Number AUG 29. 19 1**X** M 2□ F 1930 78 Yrs. 120-24-4510 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Talbot Wye Mills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 28665 Earthlite Road 21679 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 □ No If Yes, Give Year or Dates:1955—1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo Specify Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nilsen Harold Nicolai Arline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28665 Earthlite Road Wye Mills, MD 21679 Stephen M. Nilsen, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/08/09 Baltimore, MD 21228 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer phanea 2 μ ontus Due to (or as a consequence of): Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

rai", or items 23a or 28a-f show Examiner must be notified at

er than "natura", the Medical E

Health and Mental Hygiene. em 27 Is marked other thar ther traumatic event, the

permit. Pages Department of Important: If It any injury or o once.

Completed by Funeral Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending p for use as 1

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

by Physician/Medical Examine Be Completed Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the Medical

IF FEMALE:

9 🗌 Unknown		3 LI OTRITOWIT				
Part II. Other significant o	conditions co	ntributing to death but not r	esulting in the underlying	g cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
					24a. Was an autopsy performe	
25. Was case referred to r	medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 🔀 No	F	Hospital: 12 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 X Residen	ce 6 Other (Specify)
2 Accident	Pending investigation	28a. Date of Injury (Month, Day, Year,	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred
	Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, street, fact cify)	ory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
						use(s) and manner as stated. e and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Rd. Annapolis, Md

State Registrar

nound up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

		State of Maryland / Department of Health and Mental Hygiene 2 1 7 3 1 - State Registrar												
			1. Decedent's Name (First, Midd	lle, Last)							Year	3. Time of Death		
Н			Jessie Regin	a Nehring					97	ŐĨ'		1953 ^M		
we's	Examin		4a. Facility Name (If not institution	on, give street and numbe	r)		4b. City, Town, or		th		ounty of Death			
			WMHS-Braddock	-			Cumber				llegany			
	Funeral		5. Social Security Number	6. Sex 7. A 1 □ M 2 🔀 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	th ay, Year)	Cou	place (State or Foreign intry)		
	Director		214-28-6339 Usual Residence of Decedent		78	- 1101			11/18/	1930	Mai	ryland		
	land ow		10a. State 10b. County	у	10c. City	, Town or Lo	cation					10d. Inside City Limits		
	Mary Frsh	tor	MD Alleg	jany	Fro	stburg	3					1 X Yes 2 □ No		
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	ntry?		
	h with		48 Tarn Terra	ice			21532			U.S.	.A.			
	deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces		3. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No)- 14.	. Race - Amer Black, White,			
9	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the in click in a count to a count, the indical Eron, in a cust be notified at	/ Fu	1 ☐ Never Married 2 ☐ Ma	arried 1 □Yes 2 🛭			1 □Yes 2 🛣 No	Specify:	,	S	pecify: Wh			
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9	filed Hygi sther		17. Father's Name (First, Middle					18. Mother's Na	ame (First, Middle	, Maiden Su	ırname)			
Maryland	d be ental ked c	To Be	Allen B.	Britt				Nannie		Stot	cler			
ary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Address (Street	and Number or I	Rural Route Numb	er, City or T	own, State, Z	ip Code)		
\geq	rt 27		Denise Charles	sworth/ Daug	hter	21 Me	eander Cl	ose, Ca	rlisle,	IOI NC	R 1H1,	Canada		
ē,	s 1 al		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other place	e) ;	Date	20c. Loca	tion - City or T	own, State		
Ë	Pages nent o nt: If i		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (e		fts Registr	1	6/2009					
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot once.		21. Signature of Funeral Service	e Licensee		22	2. Name and Addres	ss of Facility A	natomy G	ifts I	Registr	.À		
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п			23a. Part 1. Enter the disease, of shock, or heart failure.	complications that causest only one cause on each	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between					
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	/Medical Examiner		resulting in death)	Due to (or a	as a consequ		•				. 1	V- 05		
	Examine	_	Sequentially list conditions,	b. FRE	BRO		SCULA	RA	CCIDI	SNI		1/2AR		
	red isit	jne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequ	ience ot):								
	and al-trar	Examiner	that initiated events resulting in death) Last	C Due to (or a	as a consequ	uence of):								
8760,	cate be executed physician and the burial-transit	dical E												
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Box	eath certific attending p for use as	Z/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7			23	d. Date of deli	very		
m .	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth	t at time of d		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	y 			Month	Day Year		
P.0.	that the de ned by the detached	hys	9 ☐ Unknown	9 ☐ Unknowr	1 									
S,	res tha signed be de	by P	Part II. Other significant condit	tions contributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?		
ord	w requir been si should b	ed							- 10	Yes 2∐	No 3∐ Pr	obably 4 Unknown		
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	hysician: The law his certificate has b I director, page 2 s	ĕ							perf 1 □ Yes	ormed? 2 2 100	death?	2 ETNO		
/ita	clan: ertific ctor,	Be (25. Was case referred to medical examiner?											
of \	Physic this c	ျ	1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
n c	ling F After unera	io ::	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred N 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred City or Town, State)											
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Division	or A after of Direc	ertif	4 ☐ Homicide deter	rmined building,	etc. (Specif)	y)	eet, factory, office		City or To	wn, State)	reamber of the	rai i loute Number,		
_	spita nours neral			/ing Physician: To the be										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medica one)	al Examiner: On the basis and manner		tion and/or in	vestigation, in my o	ppinion, death oc	curred at the time	, date and p	nace, and due	to the cause(s)		
	To the within To the Comp	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)									n, Day, Year)			
	1 = 4		100/	m fola	an	a.	$\mathcal{D}\mathcal{N}$	540	4		12/2	004		
	V		30. Name and address of perso	n who completed cause o	f death (Item	23a) (Type,	Print) ATT	MAN	150115	11.0	1 11/11	r MA air		
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Division of Vital Records, P.O. Box 68760,

sician and burial-trans attending physician for use as the burial ed by the a signed by t I be detach I or Attending Physician: after death. Director: After this certifica funeral director. within 24 hours a

Physician

/Medical

Examiner

Funeral

Director

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28a-f

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permit. Pages 1 and 2 should be f Department of Health and Mental I Important; If item 27 is marked of

Physician

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Examiner

injury or other traumatic

filed within 72 hours after death v Hygiene.

3altimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

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Completed

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Certification: To

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examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Re	sidence 6 MOther (Specify) hospice
27. Manner of Death ↑ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion M		e how injury occurred
3 Suicide 6 Could no determin		ctory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
	Physician: To the best of my knowledge, death occu xaminer: On the basis of examination and/or investiga- and manner stated.		
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

356 S. Center St. NAMMA 32. Registrar's Signature 0 8 2009

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner DUO. MD. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 X F NJ May 03,1931 Director 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 □ No Director Himore Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black, White, etc. Emgee 91934 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) n and Mental Hygiene. Elementary/Secondary (0-12) Representative Information 13 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) R. Smith Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if item 27 is Nottingham, MD 2123 Thomas Inni 4119 Baker 31336 Department of Health Important: If item 27 any injury or other tronce. ane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7-11-09 4 □ Donation 5 □ Other (Specify)

21. Signature of Fune ∪ Service Light ree Metro Cremotory 1232 Midvalley Dr. Jessep, PA 12434 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 dnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2□ No 1[7] 25. Was case referred to medical examiner? 26. Place of __ th Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29c. License number 032717 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

JUL 0 8 2009

DHMH 17 Rev 1/2001

d cause of death (Item 23a) (Type, Print)

Second S

09-05269 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Frank O'Mahoney O'Shea State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day July 4, 2009 Medical Examiner 1428 hrs Frank O'Mahonev O'Shea 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3901 Foxhill Drive Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Director 003-42-9100 54 11/25/1954 Country) Illinois Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Howard Ellicott City 28a-f show timore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

The file months of the state of the sta notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Foxhill Drive 21042 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces? White etc. Married Yes Widowed If Yes, Give Yea Yes 2:X No specify: Divorced Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ic event, the Medical 8 Medical Doctor Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kevin Shea Mary Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Maureen Shea/Sister 104 Chestnut Lane NW, Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State ltimore, crematory or other place) or other Burial 2 X Cremation 3 permit. Pages Department of Important: 1 07/07/2009 Hanover, Maryland Ardent Cremation Services Donation 5 Other Specify: 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses M0119 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Zaura C. Hardesty Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical Atherosclerotic cardiovascular disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): ise. Enter Underlying Car (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27,PII, per ME g894 8/12/09 TT X UNPENDED AMENDED sbeen signed by the attending physician should be detached for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic alcoholism Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 1 Yes

I fospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death After this certificate has the

Certification:

Medical

Division of Vital Director: Funeral within 2 ollo

2 No Nursing Home 5 Residence 6 ✔ Other: Scene 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 1 X Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide

O.C.M.E.

OCME

July 5, 2009

Yes 2 X No

Death

Year

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

send 31. Date filed (Month, Day, Year) State Registrar 0 8 2000

Theodore M. King, Jr., MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per FH G893 7/1709 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 **Physician** July 6, 11:20 A M James Howard O'Rourke /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9509 Marston Lane Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. October 7 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F Washington, D.C. 53 215-48-9763 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery 1 ☐ Yes 21 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9509 Marston Lane 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1982–1984 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Company Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James F. O'Rourke Marita Howard ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth O. Doyle/ Sister 2534 North Upland Street, Arlington, Virginia 22207 20b. Place of Disposition (Name of competery, crematory or other place)
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition July 8, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2009 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisonsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee 100 M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner 10 years Hypertensive Cardiomyopathy Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Depression 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an Was a...
autopsy
performed?
Ves 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1 ∐Yes 2 ∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident thours after death uneral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D33443 July 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Allan R. Pollack, 1201 Seven Locks Road#111, Rockville, Maryland 20854

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

09-05175 Sha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ade	ena Pearmo		State of Maryland	l / Department of Hea <i>Certificate of Dea</i>		rgiene Reg. No.	2009 2173					
	Dhusisis	R	egistrar . Decedent's Name (First, Middle,Last)	Gertificate of Boa		2. Date of Death	3. Time of Death					
	Physicia Examir		SHADENA	PEAR	non	Month Day June 30, 2009	23331118					
		4	a. Facility Name (if not institution, give street and number	.,	Town, or Location of Death	4c. C	ounty of Death					
			Harbor Hospital Center		more	P. Data of Right (MM/DE	D/YYYY) 9. Birthplace (State or Foreign					
	Funeral		, Social Sociality Hamilton	Mon	der 1 Year If Under 24Hrs ths Days Hours Min.	02/12/19	Country)					
	Director		216-92-9619 1_M 2×F	31 Yrs.		Oxfragili	O MARKETTOD					
	ž		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Location			10d. Inside City Limits					
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	re Maryland or 28a-f show fied at once.	휭	10e Street and Number	10f. Z	ip Code	l -	n of What Country?					
	or 28	Director	129 S. TWIN CIRCL	E WAY	21227	0.	5.A.					
)	with the is 23a se noti	필	11. Marital Status 12. Was Deced	ent Ever in U.S. 13. Was Dece	dent of Hispanic Origin?(Specify Cuban, Mexican, Puerto	pecify Yes or No-	Race - American Indian, Black, White, etc.					
	r item	Funeral	1 Never Married 2 Married Armed Force 1 Yes	2 X No		1	specify: BLACK					
`	after al", o	P, F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		2 No specify: al Occupation (Give kind of		nd of Business/Industry					
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	5-0036 led within 72 Hygiene. other than '	S	17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Maiden S	surname)					
	21215-0036 Juld be filed within 72 Mental Hygiene. marked other than c event, the Medical	စ္က	JEROME PEARM	ION SR.	SYLVI	A	CARTER					
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. unt. If item 27 is marked other than "natural", or items 23a or 28a-f she nother traumatic event, the Medical Examiner must be notified at once in other traumatic event, the Medical Examiner.	흔	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	ess (Street and Number or	Rural Route Number, City	y or Town, State, Zip Code)					
	MD id 2 shoulth and 27 is aumat		JEROME PEARMON SR.	(FATHER) 8/21 (20b. Place of Disposition (I	A ELIZABE	Date 20c. L	SADENA, MD 21/22 ocation - City or Town, State					
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	Page Page ment tant: or otl		4 Donation 5 Other Specify:	CEDAR HILL	CEMETERY O'	106/2007 134	TIMORE, MARYLAND					
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	u, q	21. Signature of Funeral Service Licensee	505E1	H H. BROW	O JR. FUNC	ERAL HOME MORE, MD 21217					
			23a. Part I. Enter the disease, or complications that cau	sed the death. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest, sho	ck, or heart Approximate Interval Between Onset and					
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	0, e be executed sician and burial - trans	edical		3a PI line a-b,	Z/, permE, g		. Date of delivery					
	760 icate l	§	IF FEMALE: 23c. If yes, o 23b. Was decedent pregnant in the 1 Live bit	utcome of pregnancy th 2 Fetal de	eath 3 Ectopic preg		Month Day Year					
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	Box 6876 e death certificate the attending phy ed for use as the	Physician/M	1 Yes 2 No 9 Unknown g Unknown		: : D-41	23e Did tobacco	use contribute to the cause of death?					
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	ding I	Ë	27. Manner of Death 1 X Natural 5 Pending	Day, Year)	1 Yes 2 No							
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	thin 24	Medical	one) 2 Medical Examiner: On the basis of and manner s	f examination and/or investigation,	in my opinion, death occurre	at the time, date and pi	ace, and due to the cause(e)					
4	F .≥ F 8	₽	29b. Signature and title of certifier		. 29c. License number	1	Date signed (Month, Day, Year)					
•			(arde Halle	lu-	O.C.M.E.	Jul	y 1, 2009					
			30. Name and address of person who completed caus		at Daltimara MD 04	201						
			Carol Allan, MD Assistant Medical		eet, Baltimore, MD 21	201						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 2009 5:15 A M Virginia Margaret Robinson /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Year) Tuly, 14,1922 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Hours 1 □ M 2 🗓 F Months Days July, Director 86 <u>217 24 8532</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Andical Experimer must be notified at Director 1 ☐ Yes 🎾 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 1424 Old Stepney Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Black Specify Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 <u>Bookkeeper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f Winfield Marion Bond Clara Kell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1270 W. Jarrettsville Rd, Forest Hill, MD 21050 Denise Berry Graham (niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gardens: 7,11,2009 Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 333 S. Parke St. Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, led ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 **N**No 1 □Yes I or Attending Physician; after death, To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 💆 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 29a. Certifler

(Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

Maryland 21215-0036

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of Vital

DHMH 17 Rev 1/2001

ACICLE JONES GINE

31. Date filed (Month, Day, Year)

DULANEY

of person who completed cause of death (Item 23a) (Type, Print) 2350

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear **Physician** RHINEHART 1:25pm ゴロレソ 5H 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HOSPITAL CENTER BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 € M 2 □ F 247-36-3117 Director 80 3/17/1929 SC Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ¥Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 21217 USA 2306 Avalon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Black "natural", Completed ed other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager University is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jeremiah Rhinehart Ethel L. Golson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Moses/daughter 27 3167 Jeffland Road Baltimore, MD 21244 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If ite
any injury or ot: 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/09 Arbutus Mem. Park Arbutus, MD Baltimore, Mu No. 21215 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Warch Funeral Home West 4300 Wabash Ave. Shanner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acuto **Physician** /Medical Due to (or as a con equence of): Examiner labetes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funearial director, page 2 should be detached for use as the bundar-transit air by the funearial director, page 2 should be detached for use as the bundar-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760-Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HyperTension 20 No 1 ☐Yes 2 ☑No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 [V/No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State→ determined 4 Homicide within 24 hours a filled Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar JR ZAW MIN, 31. Date filed (Month, Day, Year) JUL 0 8 2009



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES - 001

STREET, BALTIMORE, MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary		partment of F ertificate of			giene Reg. No.	21739
п			1. Decedent's Name (First, Middle, La.	st)			-	2. Date of Dea Month	ath Day Year	3. Time of Death
4	Physici /Medio	al	Roger William			4. 05. 7	- Landing of Daniel	July	5, 2009 4c. County of Death	12:15 A ^M
3	Examin	er	4a. Facility Name (If not institution, given Good Samaritar		nter		r Location of Death Limore	1	N/A	
	Funeral		5. Social Security Number 6. S	ex 7. Age (Ir	yrs. last birthd		If Under 24 Hrs. Hours Min.	8. Date of Birth	h 9. Birth	place (State or Foreign
п	Director		ZIJ-I4-I04J	XM 2□F	88 Yrs	Months Days	Hours Will.	May 4	, 1921 Penr	isylvania
	land bw		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	Location				10d. Inside City Limits
	Mary Fe-fah	tor	Maryland N/A		Ва	altimore				1X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	20		10g. Citizen of What Cou USA	ntry?
	eath v	erai	1903 Lydonlea Way	12. Was Decedent Eve	rin U.S.	212		pecify Yes or No-		can Indian,
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene d other than "natural", or itams 23a or 28a-f ahow avent, the Modical Examinar must be codified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:	1942 1946	3. Was Decedent of It Yes, specify Cub 1 ☐ Yes 2X No		o Rican, etc.)		etc. nite
5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra		(G	cedent's Usual Occupive kind of work done B. DO NOT use retire	during most of wor	king	16b. Kind of Business/Ir	ndustry
12	within ene than he we	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ountant	d)		Veterans A	ministration
9	be filed htal Hygi od other event, I	BeCc	17. Father's Name (First, Middle, Last,)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
/lar	2 should be to and Mental I is marked or sumatic ave	To B	William H. Saltz	gaver			Berth	na Boyer		
Man	CI 10 -= 6		19a. Informant's Name/Relationship (Catherine S. Sal		- 1				er, City or Town, State, Zi	
re, l	of Health item 27 other tr		20a. Method of Disposition		20b. Place of Di	sposition (Name of		Date Date	Mary land 212 20c. Location - City or T	
<u>B</u>	Pages lent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	•	crematory or other pla cematory $ m I^{\circ}$		06/09	Baltimore,	Maryland
Salti	permit. Pages 1 Department of H Importent: If its any injury or ot once.		21. Signature of Funeral Service Light						land Inc. ore, Marylar	
	40 = a		23a, Part1. Enter the disease, or com	olications that caused the	death Do not					nd 21228 Approximate
4	Physician		shock, or heart failure. List only Immediate Cause (Final		di H	40 cardía	1 9001	-10/	Liene n	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of)		T	201000	o y	
	Examiner	_	Sequentially list conditions,	b. Deine	ulea	Y.				
	insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or).					
o	cate be executed physicien and the burial-transit		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
8760,	cate be chysici the bu	dical	(_ d						
Box 6	death certifica e ettending ph od for use as ti	ian/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		- C-			23d. Date of deliv	rery
	0 0 2	O	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 □ 4□Pregnant at tim 9□Unknown		3 □Ectopic pregnand 5 □ Other (specify) _	·y		Month	Day Year
P.O.	requires thet the de een signed by the or hould be detached	Physi	9 ☐ Unknown Part II. Other significant conditions	contributing to death but n	ot resulting in th	e underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
of Vital Records,	quires n sign	d by						101	Yes 2□No 3□Pro	bably 4 Unknown
000	2 S S S	Completed	0					24a. Was	an 24b. Were aut	opsy findings available ompletion of cause of
ĕ	The ete h page	Com						perfo	rmed? death? 2 1 √ Yes	28 No
Vita	Physician: Th this certificete rat director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only o		
ð	Phys or this orat di	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. Inju	41 Nursing F	-	dence 6 Other (Special Control of the Control of th	ify)
ion	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		ea <i>r)</i> Inju		irk?]Yes 2∐No			
Division	o atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm Specify)	street, factory, office		28f. Location (S City or Tox	Street and Number or Rui wn, State)	ral Route Number,
-	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one)	nyminian: To the best of in miner: On the basis of ex- and manner stated	amination and/o	eath occurred at the tr r investigation, in my	opinion, death occu	and due to the irred at the time,	date and place, and due	stated to the cause(s)
-	Mithin 2 Fo the	Med	29b. Signature and title of certifier	2		29c. Licen	se number		29d. Date signed (Month	, Day, Year)
			> cheath	K. Im	Pull	1) 300°	,	Tely 6h	2009
			30. Name and address of person who	completed cause of death	(Item 23a) (Ty	be, Print) B	limere	· Hd	-21239	.=32
	Sta	ite.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1000		100		
	Regist		JUL 0 0 200	10						
DH	MH 17 Rev 1/2	001	00 000	19 Geneva	B. 1	arked				
					GAI	GINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 2,2009 10:50P Anna May Shank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🗓 F September 26,1932 Director 76 Maryland 218-28-2764 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Kodical Examina" is ust be nutflied at 1 ☐ Yes 2 No Director Nottingham Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21236 4102 Taylor Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 XNo White þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mercy Hospital Dietary Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Evelvn McNamara Robert Hutchins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa, Md. 21085 DTR. 510 Barksdale Dr. Debbie McConnell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimor 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 7-6-2009 Baltimore City, Md. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician المامة signed by the attending physician signal stran Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed?

1 □ Yes 2 ■ No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No after death Director: 3 🔲 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and ag

31. Date filed (Month, Day,

Year).

DHMH 17 Rev 1/2001

rson who completed cause of death (Item 23a) (Type, Print)

DULANEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ju^{Month}_{y} 1,2009 4:45A Genevieve H. Sachs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore <u>Timonium</u> Lorien Healthcare/ Mays Chapel Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🔀 F 82 <u>Maryland</u> August 14,1926 214-22-9780 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Balto. Rosedale Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4836 Brightleaf Court 21237 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏖 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Coffay Charles Klein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4836 Brightleaf Court Rosedale, Md. 21237 Spouse Frederick Sachs 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 7-6-2009 Baltimore City, Md. 4 Donation 5 Other (Specify) Gardens of Faith 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Fueral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) complications Dementia ears Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2009

24a. Was an

1□ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

ST 4165, BALTO, MD

2 No

28d. Describe how injury occurred

1 | Yes 2 | No 3 | Probably 4 | Onknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or ; may injury or other traumatic event, the Medical Examiner must be none.

Baltimore, Maryland 21215-0036

and burial-tran the

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

Physician/Medical ģ Completed Be ဠ

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 ☑ Natural

Certification:

Medical

State Registrar

physician certificate has birector, page 2 s

signed by the ours after death.

neral Director: After this certific filled in by the funeral director. within 24 hours a

To the Funeral I

completely filled

29b. Signature and title of centifier

31. Date filed (Month, Day, -Year)

2 No

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (item 23a) (Type, Print) KGAN-CARDEN

Hospital:

28a. Date of Injury

(Month, Day Year)

6701 N Charles

Begistrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienea and

		1	1 - For State Registrar	Otato of Ma	ylaria / Di	Certificate of	Death		g. No.	9 6114	-
	Physici	an	1. Decedent's Name (First, Middle,	Last) 1	14		2	Date of Death Month		3. Time of Deat	h A.
	/Medi	cal	4a. Facility Name (If not institution,	Schm/(ur	4h City Town o	r Location of Death	July	2, 200 4c. County of D	97 4.5/1	/
	Examir	ier	206 Sandhill Roa			Essex	Location of Death			nore County	
	Funeral Director		198-12-5074	6. Sex 7. Age 1 M 2	(In yrs. last birth	Months Days	Hours Min.	Date of Birth (Month, Day, pril 17	Year)	Birthplace <i>(State or Ford Country)</i> Pennsy1vania	-
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Lin	nits
	e Mary a-f sh tifted a	ctor	Md. Ba	alto.		Essex				1 □ Yes 2 🛣	No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code	201	10	g. Citizen of What	·	
	death v ns 23a must	eral	206 Sandhill I	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba	221 Hispanic Origin? (Speci	y Yes or No-		JSA merican Indian,	
4:57 pm altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba		can, etc.)	Black, W Specify:	White, etc. White	
15-(n 72 h "natu	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	16a. E	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	oation during most of working	1	6b. Kind of Busine	ess/Industry	
212	d withii giene. er than	Somp.	Elementary/Secondary (0-12)	College (1-4or 5+))	memaker			Home	2	
bu	be filed tal Hy d othe event,	To Be C	17. Father's Name (First, Middle, L	.ast)			18. Mother's Name (laiden Surname)		
ryla	hould id Mer marke matic	2	Louis Discavage 19a. Informant's Name/Relationsh	in (Time Print)	10h I	Mailing Address (Street	Rose Grig		City or Town Stat	te Zin Code)	
pm , Ma	alth ar 27 is er trau		Irene Plasaj	DTR.		06 Sandhil				o, Elp Code)	
7 F ore	ges 1 a t of He If item or othe		20a. Method of Disposition 1 □ Cremation	3 ☐ Bemoval from State	1	Disposition (Name of crematory or other place			0c. Location - City		
4:5 Itim	nit. Pagartmen ortant: Injury		4 Donation 5 Other (Sp 21. Signature of Funeral Service L		Garden	s of Faith	7-7-200 ess of FacilitySchim			City, Md.	
•••	permi Depa Impo any ir		Buin G	I will	عر,		ir Road Ba				
TOD			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the complications that caused the control one cause on each line	he death. Do no	t enter the mode of dyir	ng, such as cardiac or r	espiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Lunc	1 can	cer				6 MON	ths
0/	Examiner			Due to (or as a	onsequence of	:					
7/2	pe tis	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):					
/ii -	execut n and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
DOD 68760 ,	rtificate be executed ing physician and s as the burial-transit	Medical		d							
- 4	ertifica ding ph		IF FEMALE:	23c. If yes, outcome of	f progpana.						
Box	death certificate be executed e attending physician and d for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Petal death	3 Ectopic pregnance 5 Other (specify) _	су		23d. Date of Month	Day Year	
P. O.	at the	Phys	9 Unknown	9 Unknown				00 5:111			
nid ds,	signed	by	Part II. Other significant condition	ns contributing to death but	not resulting in t	he underlying cause giv	ven in Part I.	23e. Did tob		e to the cause of death'] Probably 4 ☐ Unkno	
Schmid Records,	w requ	letec	WHALL SI	Since / inc.	30. 1110.	d	orw.e	24a. Was an	1	autopsy findings availato completion of cause	
8	The la ate ha page 2	Completed						autopsy perform 1 □ Yes 2	/ prior ned? deat No 1 □	h? 🚬	of
Wanda of Vital	ilcian: certific rector,	æ	25. Was case referred to medical examiner?	Hospital:		otiont 3 DOA Oth	26. Place of Death (Check only one	,)		
	g Physer this eral dii	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatien	/ 28b. Tir	ne of 28c. Injur	rv at 28		nce 6 ☐ Other (5 w injury occurred	Specify)	
sion	ending eath. or: Aft the fun	atio	10 Natural 5 ☐ Pending investige	ation	rear) in	ury Wor M 1□	k? Yes 2□No			S-1-1-1-1	
Division	tal or Att s after de al Directo ed in by t	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		y - At home, farn (Specify)	n, street, factory, office	28	Location (Str. City or Town,		r Rural Route Number,	
6	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical		p Physician: To the best of examiner: On the basis of and manner state	examination and						
	To the company	Ž	29b. Signature and title of certifier	Vaux	E M	29c. Licens	3238	29	July	7 7000	
			30. Name and address of person v	VANIK M.I	ath (Item 23a) (T	06 Plulac	delphia Ra	1#30	4 Baltin	nove MD 21	23
	Sta		31. Date filed (Month, Pay, Year)	32. Registrar				-	1		
DH	Registi IMH 17 Rev 1/2		302 00	3 2009 Seneu	a p.	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 6:24 P SARA SHOPULSKI JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Min. | 04-11-1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) WV 1 □ M 2 🖾 F Yrs. 214-10-0329 90 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director MD Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Furnace Rd 21084 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2X No Specify Specify: White 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) aith and Mental Hygiene.
27 is marked other than "I r traumatic event, I're Moo Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Gruber Kathleen Hush ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health (Item 27) Donna Shopulski (Dtr-in-law) 1801 Furnace Rd Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 07-08-2009 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Sign ture of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of BelAir Drien Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician sund 3 ruge den disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events as a little of the cast.) Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 □ No Year Month 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown graves 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HB P cate has page 2 s autopsy performed? 1 □ Yes 2 □ No 16 certificate 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 232295 Dance 5 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year **Physician** Charles Daniel Springer, Jr. 3 July 10:10A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1**X** M 2□F Months Days Hours 408-44-3810 78 Director 12-22-1930 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h. County 10a State if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll Westminster Director 1 ☐ Yes 2x No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 948 Westcliff Ct. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Highway Bridge Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Daniel Springer, Springer Katie Dee 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 948 Westcliff Ct., Westminster, MD 211
ce of Disposition (Name of Date 20c. Location - City or Town, State Anitra Forwood Springer MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Branch Cem. 7-7-2009 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home, P.A. homas Westminster, MD 21157 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disease. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cue. Unleaded to that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and -tran Due to (or as a consequence of) physician a s the burial-1 Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death signed by the a 5 Other (specify) 2 No Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate 2 No t∐Yes 2XX No 1 ∐Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 X Natural 5 ☐ Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Ö σ. Division of Vital Records,

State

Registrar

DHMH 17 Rev 1/200

Mohit Narang

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555

(Check only one)

29b. Signature a

Center

St.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number MD434235 29d. Date signed (Month, Day, Year)

7-3-09

09-04	977 n Lulin Sydn	or J	Please Type or	Print in Blac of Maryland / I	ck Inde	e <mark>lible li</mark> ment of	n k. Ens u Health a	re All Cop nd Mental	i es Ar d Hygien	e Legib le e	e. <i>^</i>	000	0 2171.
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	Physicia	n/ 1	egistrar . Decedent's Name (First, Middle,Last)						Mon	of Death th Day 24, 2009	Yea		Time of Death 0650 hrs
Medi	ical Examin		Austin L. S a. Facility Name (if not institution, give	ydnor street and number)			4b. City, Town,	or Location of De			c. County	of Death	
			Neal Sound River	,			Issue				Charles		lana (State or
	Funeral	5	. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under 1 \		Min.	te of Birth(MN		Foreign Count	
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	any		Usual Residence of Decedent Oa. State 10b. County	1	0c. City, To	own or Loca	tion						Od. Inside City Limits
	≥	_	Md. Anne A	rundel		Glen	Burni				£ 16	/hat Country	XXYes 2 No
	Maryla 28a-f d at or	Director	0e. Street and Number				10f. Zip Coo				ISA	mat Country	,
1/2	ith the 23a or notifie		60 Glenridge	Road 12. Was Decedent E	ver in U.S	. 13. W	as Decedent of	21061 Hispanic Origin?	(Specify Y	es or No-	14. Rac		n Indian, Black,
14510	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 Married	Armed Forces?	X No	lf.	Yes, specify Cu	ıban, Mexican, Pu	erto Rican,	etc.)		ite, etc.	-1-
	after d al", or	Ð.	3 Widowed 4 X Divorced	If Yes, Give Year or Dates:			Yes 2 X	No specify: upation (Give kind	l of work do	ne 116b		Bla	
	hours 'natur Exami	g -	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	lly highest grade comp College (1-4 or 5-		during	most of working	life. DO NOT use	retired)				
	hin 72 thin 72 te. than edical	ompleted	12			Com	puter	Clerk				MVA	
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	121 Id be fi Aental narked event,	o Be	Austin L. Sydn 19a. Informant's Name/Relationship (T	vpe, Print)		19b. Maili	ng Address (A11	r or Rural F	B. Syc Route Number,	City or To	own, State,	Zip Code)
	AD 2 2 shou h and N 27 is n imatic	٩	William Sydno			411	2 Bedi	ord Rd	, B	altimo	ore,	Md . n - City or T	21207
	re, N L and Heald Fitem er tran	Ī	20a. Method of Disposition 1 XBurial 2 Cremation 3		te Ci	rematory or	osition (Name o other place)		Date	1			
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	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medie-I Examiner must be notified at once.		21. Signature of Funeral Service Licer) _	_ 22	Estep	"Brothe Entaw P	rs F lace	unera. . Bal	l Se timo	rvice re, l	PA Md. 21217
	Physician		23a. Part I. Enter the disease, or com	olications that caused	the death.	Do not ente	r the mode of o	lying, such as care	diac or resp	iratory arrest,	shock, or	heart	Between Onset and
	/Medical xaminer		failure. List only one cause on e Immediate Cause (Final disease a	Dro	ownin								Death
Н	Adminer		or condition resulting in death)	Due to (or as a conse	equence of):							
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	recuted and rand	cal Exa		AMENDED 23	2 27	28a-F	. per M	E 2893 7	79/09	TT			
	D, be exe sician a	edica	X UNPENDED				, per 1.				23d. Date	e of delivery	,
	Vital Records, P.O. Box 68760, sicion: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - trans	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		2	Fetal death	3 Ectopic	oregnancy		Mont	h D	Day Year
	ox 6 ath cer attendi	sicia	1 Yes 2 No 9 Unknow	4 Pregnant at	t time of de	eath 5	Other (Specif	y)					
	D. B. tribe de by the ached f	Phy	Part II. Other significant conditions		th but not r	esulting in th	ne underlying o	ause given in Par	t I.				the cause of death?
	of Vital Records, P.O. ing Physician: The law requires that the the this certificate has been signed by meral director, page 2 should be detach meral director, page 2 should be detach	d by							_	1 Yes			oably 4 Unknown
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	of Vit ing Physic After this funeral dir	⊢	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ing (Month, Day,		28b. Time		Bc. Injury at Work?		. Describe ho	w injury o	ccurred	
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	Division tal or Attendiirs after death. al Director: /	tific	3 Suicide 6 X Could n	ot be 28e. Place of I	njury - At l ound	iome, farm,	street, factory, L ver	office building, etc	. 281 I:	or Town, Sta	Nea	LSou	ural Route Number, City nd River
	Division Bospital or Attend 44 hours after death Funeral Director:		4 Homicide	T # 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	occurred at the	curred at the time, date and place, and due to the cause(s) and manner as stated.					ted.		
1.1	Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical	(Check only one) 2 Medical Examin	ner: On the basis of ex	amination	and/or inves	stigation, in my	opinion, death occ	curred at th	e une, date ai	iu piace, a	and due to the	
Pell	F 2 5 8	§	29b. Signature and title of certifier	Da		_	290	O.C.M.E.		ļ		5, 2009	onth, Day, Year)
			Patri Cla	- HOLL	ملر	- JL-9		U.U.IVI.E.					
7			30. Name and address of person with Patricia Aronica-Pollak		meath (Ite Medical	Examine	er 111 Pe	enn Street, Ba	altimore,	MD 21201			
		State	31. Date filed (Month, Day, Year)	32 Regist	rar's Signa		all						
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DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 5 ,38PM FLORENCE 2009 SHIRLEY SACHS JULY /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL OF BALTIMORE CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 X F NÝ Director 216-20-1563 11/29/1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🌠 No Director MD BALTIMORE **GLYNDON** 10e. Street and Number 10g. Citizen of What Country? 3675 BUTLER ROAD Completed by Funeral 21071 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than HIGHER EDUCATION ASSISTANT TO DEAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည NATHAN GOLDSTEIN FRIEDMAN BESSIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i REUVANE SACHS / SON 3675 BUTLER ROAD, GLYNDON, MD 21071 Baltimore, 20b. Place of Disposition (Name of MOSES MONTEY TORE place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODMOOR HEBREW CEM 107/09/2009 BALTIMORF, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a LARGE RETROPERITONEAL BLEED 3 bAYS /Medical Due to (or as a consequence of) **Examiner** ACUTE MYOCARDIAL INFARCTION DAYS Ecqueribility list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ACUTE RENAL FAILURE

Due to (or as a consequence of): sician and burial-trans Division of Vital Records, P.O. Box 68760, 12 DAYS PNEUMONIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ DIABETES MELLITUS TYPE II, VENTRICULAR TACHYCARDIA1 - Yes 20 No 3 Probably 4 Unknown Be Completed CONGESTIVE HEART FAILURE 24a. Was an autopsy performed? 1 □ Yes 2 🖼 No 24b. Were autopsy findings available prior to completion of cause of death? ARTERY BISEASE, HYPERTENSION 2 No CORONARY 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the nosposses within 24 hours after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar MARGARET
31. Date filed (Month, Day, Year)

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MARGARET A. OWEGI, b.O.,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RES-000

A. OWEGI, B.D. SINAI HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:15 A M Marilyn Patricia Shand Jul 4, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing Home Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min Director 219-32-2531 MD Nov 20, 1934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Howard Columbia filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 2 No 1 ☐ Yes þ Yes, Give Specify Specify: 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ages 1 and 2 should be filed wi ent of Health and Mental Hygier It: If Item 27 is marked other th y or other traumatic event, the did not work did not work 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Herschel Mullinix James ပ Alice Ferol Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Willis, Esq. 3716 Court Place Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department o Important: If any Injury or Jul 08, 2009 Marriottsville, Maryland **Crest Lawn Memorial Gardens** Scholure of Funeral 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** ATHEROSCIEROTIO DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 **N**o 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 1 ☐ Yes 2. No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ça npletely

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the within To the

> State Registrar

29b/Signatu

PANKA

31. Date filed (Month

Year)

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

D0060660

9106, PHILADELPHA RD.

29d. Date signed (Month, Day, Year)

BALTIMORGINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 3, Year Month **Physician** 12:50 PM Strausser, Sr. 2009 Lee William)uly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Square Hospital Center Rosedala Boultimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Åge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 23, 1935 6. Sex **Funeral** Min. 1 ☑ M 2 □ F Months Days Hours Pennsylvania 217-34-5287 May Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov 1 Tyes No Essex Director Baltimore Maryland 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21221 United States 10 Horney Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2K No If Yes, Give Year or Dates: Specify: ò Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry other traumatic event, the Medical Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Iron Industry 10 Years Iron Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Larkins Granvill Strausser ဂ Wife 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Villiam 10 Horney Court Essex, Maryland 21221 Mrs. Virginia L. Strausser 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of the Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp. 7/8/2009 □Donation 5 □Other (Specify) 21. Singlure of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on a ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between et and Death Immediate Cause (Final disco oronam Physician disease or condition resulting in death) /Medical as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division of Vital Records, P.O. Box 68760, 32 To the Hospital or Attending Physician; The law requires that the death certificate be executed ohysician and the burial-transi Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the ad be detached f 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s performe 1 □ Yes 2 **N**O 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 No death. neral Director: A
/ filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner_stated. 29d. Date signed (Month: Day, Year) 29b. Signature and title of 31. Date filed (Mo. nth, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year July 3, 2009 11:22 P. M **Physician** Otho Clyde Smith /Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Perry Hall Quail Run Assisted Living Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 🗖 M 2 🗆 F 85 225-20-1290 Virginia January 1, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Myddal Evaninar must be notified at Baltimore 1 X Yes 2 □ No N/A Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or USA 21206 5611 Hilltop Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1∑1Yes 2 □ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 1 □Yes 2**/X**No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fancy Birch Hessy K. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4502 Dunton Terrace-R Perry Hall Maryland 21128 19a. Informant's Name/Relationship (Type. Print) James R. Heffler/ Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page:
Department o
Important: If
any Injury or
once. 7/7/09 Baltimore Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 Muster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG **Physician** disease or condition resulting in death) /Medical HRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit DIABETES Due to (or as a consequence of): Division of Vital Records, P.O. Box $68760^{\prime\prime}$ TNEMIA Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Ye ar Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐Yes 2 ☐Mo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify ASST. Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide IN ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number Induli Tulle MD D 27/88 7-6-09'
s of person who completed cause of death (Item 23a) (Type, Print)
Le 10 Tulla 2 Maxico (- Place D undalk MD 2/22)
Day, Year)

32. Registrar's Signature
2009 Servine D. Jack

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Ye ar **Physician** JULY 2009 orinthia /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dea 4b. City, Town, or Location of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER CLEN ! BURNIE ANNE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🕓 291-34-094 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantrac must be notified an any Injury or other traumatic event, the Medical Evantrac must be notified an once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director Surnie MD 10g. Citizen of What Country? 10e. Street and Number 21061 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7/er K SMITH, PEARL Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Kober ဥ Nimmo Madison 19a. Informant's Name/Relationship (Type. Print)
William J. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sor Hanover, MO 21876

Date | £0c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 7-11-09 Anne Arundel Cty 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Vaugha C. Greene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore National Pike MD21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execute and burial-trar Due to (or as a consequence of): to the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral L 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

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		1 - For State Registrar	State of W	ai yiai i		tificate				Reg. No	009	2	752
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Physicia /Medic		LYULD			SMI				July	06	200	-	rs M
Examin	er	4a. Facility Name (If not instituti						cation of Death	FFT3.7	4c. C	County of Dea		
Funeral		5. Social Security Number			last birthday)	If Under 1	Year If	MORE CI Under 24 Hrs.		th Voor	N/A 9. Bir		ate or Foreign
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should be filed within 72 hours after death with the Maryland ind Mental Hygiene. In the Maryland indental Hygiene or parked other than "natural", or items 23a or 28a-f show umatic event, I'm Medical Examination ust be malified at	Completed	Elementary/Secondary (0-12)	6+ YEARS	5+)		DO NOT use EACHER	retired)				SCHOOL	JONIT	FODLIC
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2 shou and h is ma		19a. Informant's Name/Relation							ral Route Numb	-		Zip Code)	
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ages ant of l t: If Ite		1 X Burial 2 ☐ Cremation	3 Removal from State		Place of Dispo- emetery, cren E MEMOF			1	10/2009		NINGTO		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, In Medical once.		4 ☐ Donation 5 ☐ Other and Service 21. Signature of Funeral Service		16		2. Name and							
permi Depa Impo any ir		Heath Hay- LUNON 8521 LOCH RAVEN BLVD. TOWSON, MD 21286											
			or complications that cause st only one cause on each I	d the deat ine.	h. Do not ent	er the mode	of dying, s	uch as cardiac	or respiratory a	rrest,		Approx Interva Onset a	imate I Between and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	espira	uence of):	Failur	e						
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the de	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of o	death 5 L	Other (spec	cify)						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 💆 Certifi	ying Physician: To the bes	t of my kno	owledge, deat	h occurred at	t the time,	date and place	and due to the	cause(s)	and manner	as stated.	
n 24 h n 24 h ne Fur pletely	Medical	(Check only 2 Medic one)	al Examiner: On the basis and manners		ation and/or in	vestigation, i	n my opini	ion, death occu	rred at the time,	date and	place, and du	e to the car	ıse(s)
To ti Vithi Comi	Ž	29b. Signature and title of certi	jer /				License nu			29d. Date	e signed (Mor		
Intl		nary		1			KES-	4 6 9		JUL	4 0	6 2	००९
ov		30. Name and address of person					s ne	MO 3	1127				
Sta		31. Date filed (Month, Day, Yea	(r) 32. Regist	trar's Signa	ature	ani i i pri 0		MO 2	12 6 7				
Registr	ar	0 1141.	8 2009		# 4	10. 11. 1	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 4:25 A M 2009 VERA MAE STRAUSS July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 M 2 X F **Director** 551-34-0517 89 October 17, 1919 Florida Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the like like and the most two collings and 1 X Yes 2 ☐ No Director Maryland Frederick <u>Frederick</u> 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1713 West 7th Street 21702 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>American Red Cross</u> <u>Volunteer</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important; If Item 27 Is marked other? any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Stanley Lilly Lindsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jonathan S. Strauss / Son 1702 Jacob Brunner Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery crematory or other place)
Arlington National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State September 10, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, Virginia 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Affen -M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks Aspiration /Medical Due to (or as a consequence of): Examiner Concestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed sician and burial-trans attending physician the as nse for P.O. signed by the a Records, has Division of Vital Physician: funeral director, e Hospital or Attending P 24 hours after death. e Funeral Director; After t completely filled in by the

show

death with

72 hours after

Baltimore, Maryland 21215-0036

3 Suicide

4 Homicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinery on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> D43091 TOLL House Are

29d. Date signed (Month, Day, Year)

State Registrar

Medical

Saun 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MI) Cardi Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&19b Per FHS (2893) Malykana / Wepartment of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Deal 1. Decedent's Name (First, Middle, Last) Ye ar Month **Physician** 3, 2009 1:31 A July Louise Hardy Schindel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🕱 F 81 July 9, 1927 Washington, D.C. 579-36-3818 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2 😿 No Director Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20817 6733 Newbold Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🔯 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anderson D. Hardy Be Genevieve M. Friel ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Cede) 19a. Informant's Name/Relationship (Type. Print) 6733 Newbold Drive, Bethesda, Maryland 20814 Jack A. Schindel/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition July 9, Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service License M01498 23a. Part 1. Engle the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 五No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Records, Vital ō Division

physician and s the burial-trans be execut attending p for use as t ned by the a s been signed b should be deta has e 2 s page certificate or Attending Physician: After this certific funeral director, Director: / thin 24 hours a the Funeral D the Hospital

with the Maryland

ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at

item 27 is marke other traumatic Pages 1 and 2 should nent of Health and Mer

nd 2 should be filed within 72 th and Mental Hygiene. Maryland 2121

Baltimore,

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Lee R. Pennington, M.B.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D21115

29d. Date signed (Month, Day, Year)

July 3, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10215 Fernwood Road, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) July 6, **Physician** 12:35 A ^M 2009 Talbot John Mayo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 8, 1913 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1**▼**M 2□ F California 96 Director 562-54-0985 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 □Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examination to a reflined at Annapolis Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 USA 2509 Carrollton Road Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give 1938–1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Medicine / U.S. Airforce Elementary/Secondary (0-12) College (1-4or 5+) Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Florence S. Mayo **Talbot** John ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ss 1 and 2 sh of Health and item 27 Is n Annapolis, MD 2509 Carrollton Road Margaret Jane Talbot, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of H Department of Important: If it any Injury or or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 07/07/09 Baltimore, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb 21228 299 Frederick Road Baltimore, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner per afron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) **♦ Natural** 5 Pending investigation To the nospectation within 24 hours after death.

To the Funeral Director: After the function of the function 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uclu

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year 3:20 PM Ross Horace Taylor 30 2009 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 M M 2 □ F 77 Yrs 148-22-9077 2/19/1932 New Jersev Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2 No FLBav Pamama City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 714 Water Oak Drive 32408 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Route Delivery Man Wholesale 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ross Dodwell Taylor Helen Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Cantell/ Daughter 1611 Turkey Point Rd. Essex, MD 21221 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 7/6/2009 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MITTE 1CW3 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

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31. Date filed (Month, Day, Year)

JUL 0 8 2009

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the five disall Exactinate rust be notified at once.

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

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3

law requires that the death certificate be executed physician and s the burial-trans attending p s been signed by the should be detached certificate has be rector, page 2 s

filled in by

Division of Vital Records, P.O. Box 68760,

	_ d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
	contributing to death but not resulting in the underly	ring cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 🔼	
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing Ho	ome 5 Residence	6 Dother (Specify) And Dice
27. Manner of Death ↑ Sol Natural 5 ☐ Pending 2 ☐ Accident investigatio		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred
3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
29a. Certifier Check only one) Certifying Pl	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place gation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c License number	294 [Pate signed (Month Day Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

09-05245 Brannon Trinko		Ple			r Print in of Marylar								jible.			
		1- For State Registrar 1. Decedent's Nan						ate of De					g. No.	20	3. Time of E	2175
Physicia Medical Examin	er	Brannon	David	Tr	inko						l N	Month Uly 3, 200	Day	Year	2010 h	
		4a. Facility Name Franklin Sc		-	street and num	ber)			ty, Town, o	or Location of	Death			ounty of Dea timore Co		
Funeral		5. Social Security		6. Sex	ł	. Age (In y			Inder 1 Ye					For	Birthplace (Stat	
Director		215-96-8		1 X	M 2 F	31	-	Yrs.	Situis De	110010	A	pril	18,19	978 0	Country) Ma:	ryland
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with the Maryland		4704 Vi	.cky Ro	ad					21	236				USA	Δ	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Marr			12. Was Dece	ces?				lispanic Origir an, Mexican, F			14	Race - Am White, etc	erican Indian, I	Black,
after de	E F	3 Widowed			1 Yes If Yes, Give Year or Dates:	2 X N		1 Yes					111		/hite	
2 hours	Completed by	15. Decedent's E Elementary/Sec	, ,	cify only	y highest grade College (1-4			Decedent's Us during most of				done	16b. Kind	d of Busines	s/Industry	
036 within 7 ene. er than	egu.	12					Pe	rsonal	Assi						County	Schoo
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be ငိ	17. Father's Name	,,	,							`	st, Middle, N . Vau		irname)		
21; hould b nd Men is mar		19a. Informant's N					19	b. Mailing Add	ress (Str		er or Rura	Route Num	ber, City			
e, MI and 2 s Fealth a item 27		Mary Tri 20a. Method of Dis			Мо	ther 2		4704 V of Disposition	Name of o			inghar ^{ate}			36 or Town, State	
altimore, mit Pages I ar partment of Hea portant: If ite		1 X Burial 2			Removal from	,		tory or other pl	ace)		7-8-2	2009	Mide	dle Ri	lver, M	d.
Balti permit Departm Imports injury o	Ì	21. Signature of Fi			ee	, -				ss of Facility	Sc	himun	ek Fı	inera]	Home	
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/Medical caminer		Immediate Cause or condition result	(Final disease	a	Combi			lone an	d al	prazola	am in	toxica	ation	1		eath
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Box 68760, re death certificate be the attending physici end for use as the buri		IF FEMALE: 23b. Was decedent		ne	23c. If yes, ou	tcome of p	pregnancy	Fetal de			pregnancy			Date of delivionth	very Day	Year
ox 6 eath cerl attendii	sicia	past 12 month 1 Yes 2		known		nt at time o	é donth	5 Other (, ,				,	
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for I		Part II. Other sign	ificant condit	ions (contributing to		ot resultin	g in the under	ying cause	e given in Par	t I.	23e. Did to	bacco us	e contribute	to the cause o	f death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rape death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ed by)										1 Yes	-		Probably 4 autopsy findin	
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1 of Vital Records ling Physician: The law requi After this certificate has been funeral director, page 2 should	οl	25. Was case refe	rred to medica	· L.					26.Pia	ce of Death (0	Check only	1 Yes	2 No	1 🗸	Yes 2	No
f Vits Physici er this c	9 P	examiner? 1 Yes 27. Manner of Dea	2 No	Ho	ospital: 1 In			utpatient 3	DOA I	Other ₄	Nursing H	ome 5	Residenc		ther:	
on o ending sath. or: Afte	Certification:	1 Natural	5 Pend		(Month, I	Day,Year)				Yes 2X		nk	now mjury	occurred		
ivisi I or Att after de Direct		2 Accident 3 Suicide	6 X Coul	stigation d not be rmined	e 28e. Place		At home, f	arm, street, fac		e building, etc	. 281	Location (S	Street and	Number of 04_Vi	Ryral Route N	umber, City
hou hou		4 Homicide 29a. Certifier (Check only			n: To the best			ath occurred a	t the time,	date and place		otting to the caus			stated.	
To the within 2 complet	Medical	one) 2 🗸	Medical Exa	miner:(On the basis of and manner sta	examination			n my opini	on, death occ			and place	e, and due to	the cause(s)	
	2	29b. Signature and	- 1) T	11					nse number C.M.E.				ite signed <i>(</i> 5, 2009	Month, Day,Ye	ar)
	1	30. Name and add	ress of person	who co	ompleted cause	of death (Item 23a)									
	10	Margarita K		Ass	sistant Medi	cal Exar		111 Penn	Street,	Baltimore,	MD 212	201				
Sta Registr	-		0 8 200	9	Z. Reg	واد د اداد	4	arkel								
DHMH 17 Rev 1/200	01	4 4 4			1		OF	RIGINAL								

		1 = For State Registrar	State of Maryla		artmen rtificat			nd M		giene Reg. No.	009	21	158
Division		1. Decedent's Name (First, Middle, Last)			,,,				2. Date of De	ath Day	Year Year	3. Time of	
Physic /Medi		Kathryn B. Tayl	or						July		009	6:15	Р м
Exami		4a. Facility Name (If not institution, give s				Town, or L		Death			county of Death Carrol		
		Longview Nursin		a for a finishing of a col		ches	If Under 2	04 Hrs	9 Date of Bir			place (State o	r Foreign
Funeral		5. Social Security Number 6. Sex 215-26-1666	M 2 F 7. Age (In yo	s. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir Month, Da 12-10	792	9	untry)	i i oreigi
Director		Usual Residence of Decedent									Mar	yland	
yland		10a. State 10b. County MD Carro		City, Town or Lo Westmi								10d. Inside Ci	-
Mar.	to	MD Callo	11	Weschil	.IIS CE	: L						1 🗌 Yes	24_ N
or 28	ire	10e. Street and Number			10f. Zip					•	en of What Co	untry?	
ter death with the Marylar tems 23a or 28a-f show trat must be tadfilled at	Funeral Director	2209 Old Washin	gton Rd.			2115					ISA		
r dez	ne	The state of the s	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	tent of His city Cuban	panic Orio , Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		 Race - Amer Black, White 	e, etc.	
s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2 ∑ No	Specify:			3	Specify: Wh:	ite	
within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show re Medical Evanitrar must be codified at	ed b	15. Decedent's Educ		16a. Dece	dent's Usua	al Occupat	tion	_		16b, Kin	d of Business/l	ndustry	
in 72 n "na	plet	(Specify only highest grade	completed)	(Give	kind of wo DO NOT u	rk done du se retired)	iring most	of work	ing			·	
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	To B	Paul Newcomer	Bish				Mar	cel.	la Alt	land			
s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)	оө, <i>Print)</i>	19b. Maili	ng Address	(Street ar	nd Numbe	r or Run	al Route Numb	er, City or	Town, State, 2	ip Code)	
and and a salth		Robert O. Taylo					hing		Rd.				21
0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo	matory or c	ther place)		Date		ation - City or		Б
artment of locations of interests of interests of interests of interests of or		4 Donation 5 Other (Specify)	Ca	arroll	ton (Jem.	1	-8	2009	west	tminst	er, M	ע
permit. Pag Depertment Important: any njury o		21. Signature of Funeral Service License	Flitter-	722	2. Name ar 2.54 E			J	Fletch , West				
Physician /Medical Examiner prisi-Itansit	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	ngest	card	y'om	Joh	Failur athy			Jean Jean	
The law requires that the death certificate the has been signed by the attending phypage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es ⊅ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	∃Ectopic p ∃ Other (s,					2	3d. Date of del Month	,	Year
uires that signed b Id be det	۵	Part II. Other significant conditions con	stributing to death but not re	esulting in the u	nderlying o	ause giver	n in Part I.		1	tobacco us Yes 2	se contribute to]No 3 ☐ Pr		death? Unknov
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Physician: this certificanal director,	0 13	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 D	Otho	-		ome 5 Res		□Other (Spe	cifv)	
fter	H	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work	at		28d. Describe			<i>,</i>	
Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined							(Street and own, State)	Number or Ri	ural Route Nur	n <i>ber</i> ,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical Co		sician: To the best of my k ner: On the basis of exami										(s)
et et e	Med	29b. Signature and title of certifier	and manner stated.		29	c. License	number			29d. Date	signed (Mont	h, Day, Year)	
To CO								577				2009	
		30. Name and address of person who co	mplated cause of death //	am 23a) /Tun-	Print\		V 3 (ر ۽ ر	, M ^z		7 01	220)	
		- 1		іөт 23а) (тура, Ма <i>∽</i>	5t-	Rei	steat	cus	, Mr	> 2	1136		
C.	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sig				-,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
AMEND TIEM#¢, perfit, C893, 7/15/09, WS

Reg. No. 2 [] [] G 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jack T. . Thompson 2009 05:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Genisis Elder Care Severna Park Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 X f Director 64 July 22 1944 214-44-9685 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, it e Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 way Injury or other traumatic event, it is Medical Examinar must be reported. 517 Windham Court 21146 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No If Yes, Give 1963 − Year or Dates: 1967 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: ģ 3 Widowed 4 Divorced 1967 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sr. Material Specialist Northrop Grumman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Lee Thompson Luella Catherine Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Windham Court, Severna Park, MD 21146 Lana J. Thompson (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 30 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Inc. 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that shock, or heart failure. List only one (au e on caus eagh ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 □Yes 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation safter death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and tit erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 8 2000 31. Date filed (Month, Day 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician 2009 3:13 Рм Thomas J. Tourish, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 2, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Michigan Months 1948 1**X** M 2□ F 209-36-8329 60 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or United States 2802 Blaine Drive 20815 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 1 ☐Yes 2X No If Yes, Give 1 ☐ Never Married 2X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Be Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ot Thomas Joseph Tourish Valeria Ann Fortuna 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 2802 Blaine Drive, Chevy Chase, Maryland 20815 Deborah L. Dokken Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If Ite any Injury or ot July 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Fungral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Sugarette Danie M01305 23a. Part 1. If ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pseudomyxoma Peritonei **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the drifting Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Feta! death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Vear 5 Other (specify) page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760, of Vital Records, Division

Hospital

within 2

filled in by the funeral director, e Funeral

29b. Signature and title of certifier Louertehou, MD

4 | Homicide

29a. Certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

637U July 3, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

6001 Muncaster Mill Road, Rockville, Maryland 20855 Jocelyne Kouatchou, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 0 8 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death

Physician /Medical Examiner	
Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

	•	1 - State Registrar	Cei	tificate of Death	Reg. N	0.2009	21761
		1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		2. Date of Death		3. Time of Death
sicia		Donald Allen Thompson				ay Year 2009	7:15 A ^M
edic: mine		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Death	-	c. County of Death	7 . 23
		Shady Grove Adventist H	ospital	Rockville		Montgome	rv
rai		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	g. Birth	place (State or Foreign
tor		104-10-9052 182 M 2□F	91 Yrs.	Months Days Hours Min.	July 26, 191		York
		Usual Residence of Decedent					
1	Ļ	10a. State 10b. County	10c. City, Town or Lo	cation .			10d. Inside City Limits
	cto	Maryland Montgomery	Rockville				1 XYes 2 No
	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Cou	ntry?
	<u>a</u>	414 Silver Rock Road		20851	Uni	ted State	es
	Funeral	Armed F	cedent Ever in U.S. 13. \ forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes	2 No	I □Yes 2 ☑ No Specify:		0 - 17	
	d by	3 ☐ Widowed 4 ☐ Divorced Year or	Dates:			W11.	
	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	dent's Usual Occupation kind of work done during most of worl DO NOT use retired)	king [Kind of Business/Ir	dustry
	dw		(1-40r 5+)				
		12	Mecha	nical Engineer		fense Con	tractor
	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Maide	en Surname)	
	ို	George Thompson	I	Nellie H			
		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ig Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zi	o Code)
		Grace Marie Thompson/Wi		ilver Rock Road,	Rockville,		
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fron	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place) Tromptorium The 200	Date 20c.	Location - City or To	own, State
		4 □ Donation 5 □ Other (Specify)		Crematorium, Inc. 2009	9 'Be	thesda,Ma	ryland
опсе.		21. Signature of Funeral Service Licensee	22 D -	. Name and Address of Facility			. 1
8	-	Butting Blut	M01548 30	bert A. Pumphrey Funer O West Montgomery Aven	al Home/ Kockv ue. Rockville	Maryland	20850
		23a. Part 1. Enter the disease or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent				Approximate Interval Between
an		Immediate Cause (Final		* 0			Onset and Death
al		resulting in death)	piratory Failu o (or as a consequence of):	.re			
er		Pne	umonia				
	ē	Sequentially list conditions.	(or as a consequence of):				
	Examiner	Cause (Disease or injury					
	Exa	that initiated events c resulting in death) Last Due to	(or as a consequence of):				
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	Medical	u					
		IF FEMALE: 23c. If yes, o	utcome of pregnancy			23d. Date of deliv	rerv
	clar	in the past 12 months?	e birth 2 ∐ Fetal death 3 L	Ectopic pregnancy Other (specify)		Month	Day Year
	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk		201101 (000011)/			
i	Completed by Physician	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
	â	Renal Failure			1 □ Yes	2⊠No 3□ Pro	bably 4 Unknown
	ete			*			
	du				24a. Was an autopsy performed?	24b. Were aut	opsy findings available ompletion of cause of
	S				1 □ Yes 2 🖾	death? No 1 □ Yes	2 🗆 No
	Be	25. Was case referred to medical examiner?		T	th (Check only one)		
	0		Inpatient 2 ER/Outpatier		ome 5 Residence	6 ☐ Other (Spec	fy)
	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Dat (Mo	e of Injury 28b. Time of nth, Day, Year) Injury	28c. Injury at Work?	28d. Describe how inj	jury occurred	
	gi	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
.	Ĭ∣	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plac	e of Injury - At home, farm, str ding, etc. (Specify)	eet, factory, office	28f. Location (Street : City or Town, Sta	and Number or Run ate)	al Route Number,
ļ.,	3						
	ca	29a. Certifier 1 Certifying Physician: To the	ne best of my knowledge, death	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause	(s) and manner as	stated.
.	Medical Certification: To	one) and ma	nner stated.	gamen, and opinion, doubt occu	quite a	piwoo, unu uuc	
	Σ	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month	Day, Year)
		Machen Hebby	rus	62562	Ju	ly 2, 200	9
	Ì	30. Name and address of person who completed car	use of death (Item 23a) (Type,		1	, ,	
		Mdhavi Hubbly, M.D.	9901 Medical C	enter Drive, Rock	ville. Mar	vland 208	550
Stat	e		Registrar's Signature		, mar		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 July 3, 4:24 Рм Kaye White 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Jan 23, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 1940 69 Maryland 218-36-5444 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Baltimore Halethorpe <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 409 Gun Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Mae Bryant Charles W. Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John G. White Jr., Husband 409 Gun Road Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. : 07/06/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading L. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

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Examiner

Physician/Medical

Completed by

Be

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Certification:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Maryland 21215-0036

ML

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed t icate has been si ; page 2 should b certificate After this certific funeral director,

P.0.

Records,

of Vital

Division

the Hospital or Attending

within 24 hours arter community to the Funeral Director: Aftermolately filled in by the fur

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 1 ☐ Yes 2

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

6 Other (Specify) OSPICE

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ACTITUDE and manner stated.

26. Place of Death (Check only one)

29b. Signature and tille of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of ause of death (Item 23a) (Type, Print) 2300

State Registrar

6 Could not be determined

DHMH 17 Rev 1/2001

		For	Sta	te of Mar	yland / Depa	artment of H	lealth and	Mental Hyg	giene					
		State Registrar			Cei	rtificate of	Death	F	Reg. No. 2 ()	0.9	21763			
Physicia	n	Decedent's Name (First, M.						2. Date of Dea Month	ath Day	Year	3. Time of Death			
/Medica	al -				oh Walsh				Jul 4, 2009	of Doodh	4 A IVI			
Examine	r	4a. Facility Name (If not instit				4b. City, Town, or			4c. County of	4c. County of Death Howard				
		5249 W. 5. Social Security Number	Running Br		f201 (In yrs. last birthday)	If Under 1 Year	Columbia If Under 24 Hrs	S. 8 Date of Birt	h		rard ace (State or Foreign			
Funeral Director		220.82.9426	1 1 M 2		44 Yrs.	Months Days	Hours Min	. (Month, Day	y, Year)	Countr	Ohio			
D.	H	Usual Residence of Deceden					<u> </u>	Aug	12, 1964	Lie				
show	- 1	10a. State 10b. Con		1	0c. City, Town or Lo	cation				100	d. Inside City Limits 1 ☐ Yes 2 No			
Ba-f	Director	MD	Howard			101 7: 0: 1:	Columbi	T	10g. Citizen of W	That County	~			
a or a		10e. Street and Number	#440			10f. Zip Code	04044		rog. Gilizeri oi W					
hours after death with the Maryland tural", or items 23a or 28a-f show at Ever-ir ar must be mutified at	Funeral	5495 Cedar Lane		s Decedent Ev	er in U.S. 13.1	Was Decedent of H	21044 Iispanic Origin? (Specify Yes or No-	14. Race	U.S.A - America				
r iten	ᇤ	1 Never Married 2	Married Arn	ned Forces?. Yes 2 No		Was Decedent of H		rto Rican, etc.)	Black	k, White, et				
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d be f ental	Be	17. Father 3 Warne (1 1104, 11114		∕id R. Wal	eh		TOT MOUTOT O THE		n Mary Del					
shoul nd M mari mati	ှ	19a. Informant's Name/Relat				ng Address (Street	and Number or F				Code)			
nd 2: alth a 27 Is		David Walsh F	ather		524	9 W. Runnin	g Brook Rd	l. #201 Colu	ımbia, MD	21044				
item of He		20a. Method of Disposition			20b. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location -	City or Tow	n, State			
Page ment ant: If ury o		1 Surial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Other		from State		uis Cemetery		ıl 07, 2009	Clark	ksville,	Maryland			
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exagnes.		21. Signature of Funeral Ser	vide Licensee	3 2 100	22	2. Name and Addre	ss of Facility uneral Home	D A						
₫ D = 6 0	4	1 may	1 Miles	HILL	MU2931	3871 Ol	d Columbia I	<u>Pike Ellicott C</u>			American			
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Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	a		FL FA	LUPLE					p p			
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that the de detached the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	ine or deam 51	Other (specily) _								
es that igned by be deta		Part II. Other significant cor	nditions contributing	ng to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contr	ribute to the	e cause of death?			
v requires been sign should be	od by	Aug	LOUIS	4				101	Yes 2□No	3 ☐ Proba	ably 4 🗆 Unknown			
The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Completed	CATA	TUIL "	tun	OMBOL	MIDPE	NIA	24a. Was		Nere autop	sy findings available			
ician: The lav certificate has ector, page 2	Ē.	Dr Pn	CS 12	n/				- autop perfo 1 □Yes	rmed?/	death? I □ Yes :				
ertifica ctor, p	Be	25. Was case referred to me examiner?	dical					eath (Check only o			Calbass			
hysic this o	၉	1 Yes 2 No	Hospita	1 Inpatient			4 🗀 Nursing	Home 5 ☐ Resid		er (Specify	TES GENC			
Attending Physician: r death. ector: After this certific by the funeral director, i	<u>:</u>	27. Manner of Death 1 ☐ Matural 5 ☐ Pe	ending	. Date of Injury (Month, Day,	Yea <i>r)</i> 28b. Time o	Wor	k?	28d. Describe l	how injury occurr	ed				
death death stor: / the f	icat	3 ☐ Suicide 6 ☐ Co	vestigation ould not be	Place of Injury	/ - At home farm str]Yes 2 □No	28f Location (Street and Numb	er or Ruml	Route Number			
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	S S				my knowledge, deat									
he Ho n 24 h	edical	(Check only 2 Med one)		n the basis of e	examination and/or in ed.	vestigation, in my	opinion, death oc	curred at the time,	date and place,	and due to	the cause(s)			
To the comp	ž	29b. Signature and title of ce	rtifier	1		29c. Licens	se number	à	29d. Date signed	d (Month, E	Day, Year)			
).		Jeff re	1111	Cell	ru)		3 141	1	07/	05	12009			
		30. Name and address of pe	rson who complete		ath (Item 23a) (Type,	Print) 5-11	o por	sky n	ALL	onic	(1/2			
Į V		31. Date filed (Month, Day,	Year)	32. Registrar	S Signature	y ec	-L(w:	rair	y w	107	104 6			
State Registra		JUL	0 8 2009	1	. 4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 893 7-8-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09:44 AM Walker July 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number of Medical Center Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F Min 214-56-564 56 NOVEMBER 18,1952 MARYLAND Director Usual Residence of Decedent with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exprised in the Collect at 1 XYes 2 □ No BALTIMORE Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 2 Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) if Health and Mental Hygiene. College (1-4or 5+) CLERK POSTAL S DERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JUHNSON ATHERINIE WILLIAM ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Freemont Ave. Balto. Md, 21201 DAVINA MALL (DAUCHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEMETRY 07/07/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

OSEPH H. BROWN JR. FUNERAL HUME 21. Signature of Euneral Service Licensee leamo 8140 N. FULTON AVE, BALTIMORE, MD 21219 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No ed by the 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗆 No 1 □Yes 2 □N 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မှ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury death. 1 □Yes 2 □ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1992964191

DHMH 17 Rev 1/2001

State

Registrar

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Greene

32. Registr

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Biskup

08 2009

31. Date filed (Month, Day, Year,

Toni

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 41 **Physician** PM 3 Watson 04 09 marnin 07 /Medical 4c. County of Death er Location of Death 4a. Facility Name (If not institution, give street and number) Examiner me Maryland General 8. Date of Birth If Under 1 Year | If Under 24 Hrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F Funeral Days Usual Residence of Decedent 10b. Cou Director death with the Maryland 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of W 10502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: by 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aborer First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Rural Route Number, City or Town, State, Zip Code Informant's Name/Relationship //Type Address (Street and Number or Md. 21211 or Town, State 20a. Method of Disposition 1 Burial A Cremation 3 Removal from State 4☐ Conation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 237. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, scock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmr diate Cause (Final di ease or condition resulting in death) Physician Sarticemia /Medical Due to (or as a consequence of): **Examiner** Uninary Sequentially list conditions, if any, leading to immediate cause. Enter or corning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): the attending physician or Vital Records, P.O. Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2N0 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division To the Hospital or Attending 5 ☐ Pending investigation 1. Natural 1 🗌 Yes 2 No death. 2 Accident the within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune completely fi and manner states 29d. Date signed (Month, Day, Year) 29c. License number 043386 7.4.09 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21217 Howard, Daniel 4 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

09-05124 Tavo

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		Donie	r State	le Leet\		Certin	outo or			2.	Date of Dea	th	Year	3	. Time of Death
Physici	٠	1. De	ecedent's Name (First, Midd								Month June 29, 1	Day 2009			1115 hrs
Exami	ıner		Tavon Jamal War Facility Name (if not instituti	ker_	ot and nur	mher)	4	o. City, Town, or	Location of	f Death		4c	. County of	Death	
			-acility Name (if not instituti Jniversity Hospital	Jii, give sire	et and no	TIDOT /	Į.	Baltimore							
				6. Sex		7. Age (In yrs. last t	oirthday)	If Under 1 Yes	ar If Under	r 24Hrs.	8. Date of B	rth(MM/	DD/YYYY)	9. Birthr Foreign	place (State or
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Director	1	21	7-96-6381	1X M	2F	28	Yrs.								
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laryk 28a-f ato	Director	10e	Street and Number						~		ľ		US	:Δ	
the N a or	吉	48	11 Aberden Aveni	æ				2120 s Decedent of H		nin2 (Sno	oify Ves or N	lo-			ean Indian, Black,
eath with the Maryland items 23a or 28a-f show ust be notified at once.	<u>a</u>		Marital Status		. Was Dec	cedent Ever in U.S.	13. Wa	s Decedent of F es, specify Cuba	an, Mexican	, Puerto F	Rican, etc.)		White		
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72 hc n "ns	# P		Elementary/Secondary (0-1	2)	College (1-4 or 5+)	Lob	orer				lini	rrett S	nepa	rd
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5-0036 ted within 72 hours after Hygiene. other than "natural",	3	17	. Father's Name (First, Midd	le, Last)							Isaac				
21215-0036 Juld be filed within 72 hours af Mental Hygiene. Marked other than "natural consent the Medical Examin	8 8	' _	Ollie Walker		5111		10h Mailir	g Address (St	reet and Nu	mber or F	Rural Route	lumber,	City or Tov	vn, State	, Zip Code)
21 ould Me	<u>اؤ</u> ا		a. Informant's Name/Relation		e, Print)		/1811	Aberden A	venue.	Balti	more. M	D 21.	206		
and 2 should be filted within 72 hours after death with the Maryland neatls should be filted within 72 hours after death with the Maryland featth and Mental Hygiene.	E		abrina Newby/ Mo	tner		20h Pl	ace of Dispo	sition (Name of	cemetery,	T	Date	20	c. Location	- City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiren 27 is nameded other than Important: If tiren 27 is named to Medic than 10 permit of the Medical pages of the Medical pages.	=	20	a. Method of Disposition X Burial 2 Crema	tion 3	Removal		ematory or c	ther place)				, D	_1		•
nol	Ē	4				Wes	tem Ce	metery_		17-11	-09	<u></u>	altimo	re, M	Balto. Co.
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Berry Dept.	Ē,	d	andou	μ.	all	11W		92W LID	rty ko	au, re	or respiratory	arrest.	shock, or h	eart	Approximate Interval
Physicia		23	Ba) Part I. Enter the disease failure. List only one ca	, or complica	ations that	daused the death.	Do not enter	the mode or dy	ng, such as	Cardiao	, roopa.a.,				Between Onset and Death
ledic				N //-	ultiple C	Sunshot Wound	ds								
amineم۔	ег	0	mmediate Cause (Final dise r condition resulting in deat		ue to (or as	s a consequence of):								
			sequentially list conditions,	b											
		if	any, leading to immediate tause. Enter Underlying Ca		ue to (or a	s a consequence of):								
		Ē	Disease or injury that initiat	ed	ue to (or a	s a consequence of	·):								
p	nsit	Examiner	events resulting in death) L	ast d.											
executed an and	for use as the burial - transit	ᇹᄂ	UNPENDED		AMENDE	D									
O, e be e sicia	buria	<u></u>			23c If ve	es, outcome of preg	nancy						23d. Date		ery Day Year
376 ificati	s the	Physician/Medi	F FEMALE: 3b. Was decedent pregnan	in the	1 Liv	e birth	2	Fetal death	3 Ect	opic pregr	nancy		Month		Day
certin	use a	<u>S</u>	past 12 months?		4 Pr	egnant at time of de	eath 5	Other (Specify)				_	l		
30) death	d for	S	1 Yes 2 No 9			known		darking co	uco given ir	Part I	23e.	Did toba	cco use co	ontribute	to the cause of death?
tribe by the			Part II. Other significant co	onditions	contributir	ng to death but not r	esulting in tr	ie underlying G	use given ii	i i dici.					robably 4 Unknown
es the	be de	Completed by									24a	Was an	24	b. Were	autopsy findings availab
ds, equir	onld	l e									-	autopsy	/	prior t death	to completion of cause of
COT law I	2 sh	힏									1 🗸	Yes 2		1 🗸	
tal Reco cian: The law	rector, page	3		-disal				26.	Place of De	eath (Che	ck only one)				
Les in an	ector	å	25. Was case referred to meaniner?		ospital:	✓ Inpatient 2	ER/Outpat	ient 3 DD/	Other	4 Nur	sing Home	5 R	esidence	6 Ot	ther:
hysid ≤	F 3	٥l	1 ✓ Yes 2 N)		Date of Injury	28b. Time		c. Injury at \	Nork?			ow injury oc	curred	
of and	unera	Ë	27. Manner of Death 1 Natural 5		Jun	Aonth, Day Year) 29, 2009	0955 hrs	;	1 Yes	2 🗸 No	Subjec				
ion tend	the	aji	2 Accident	Pending Investigation		Place of Injury - At	home farm	street factory.	ffice building	ng, etc.	28f. Loc	ation (St	reet and No	umber or	r Rural Route Number, C
ViS or At fter d	in by	읡	3 Suicide 6	Could not b	be		nome, ram,	31.001, 100101)			or T 2100 Br	own, Sta ighton	^{ate)} Street, Ba	ltimore	, MD
pital Di	filled in by the funeral	Certification:	4 V Homicide	determined		ecify) Field			mo dato ar	nd place		0.00000	(c) and ma	nner as :	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	To the Funeral Director: completely filled in by the		29a. Certifier 1 Certify	ing Physici	ian: To the	e best of my knowle asis of examination	and/or inves	stigation, in my	pinion, dea	th occurre	ed at the time	e, date a	nd place, a	and due t	to the cause(s)
o the	othe	Medical			and man	ner stated.		290	License nui	mber			29d. Date	signed	(Month, Day, Year)
	- ŏ	ž	29b. Signature and title of	certifier		Λ.			O.C.M.E				June 30	0, 2009	9
			Kit ()	ra	ll s			U.U.IVI.L						
)	ł		30. Name and address of			cause of death (Ite	em 23a)	444.5		t Politic	nore MD	21201	1		
	ŀ		Patricia Aronica-		D. As	sistant Medica	Examine	er 111 Pe	nn Stree	ı, Baltır	nore, MD	2120			
	S	ate	31. Date filed (Month, Day	,Year)	j	2. Registrar's Sign	ature	4 4							
R	egis		00.00	0 2000	12	me &	· And	Hal.							
DHMH 17 R	ev 1/2	2001	- 552	J: 2000	1.60		ORIG	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MOTEY **Physician** GLORIA JEAN WHITTAKER 2009 2:10A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 29 5. Social Security Number 7. Age (In yrs. last birthday) 200 Funeral Days Hours Months 1 □ M 2 □XE 64 1945 Maryland 219~42~0892 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ral", or items 23a or 28a-f shov Examinat must be notified at 1 ☐ Yes XX No Director Baltimore Baltimore County Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 9133 Avondale Rd. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Gloria 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify Completed by XX Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Mudical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 8 elementary/Secondary (0-12) other than Housewife Housekeeping-Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be 1 lealth and Mental John DePasquale Doris Mary Smith P traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Gereli (Daughter) permit. Pages 1 an Department of Healt Important: If item 27 any injury or other tr. once. 2106 Jacobs Well Ct. Belair. Md. 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 7~10~2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee 2685344AdFUAFETUI Home 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ISCHEMIC BOWEL DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et al. orderlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year jo 5 Other (specify) signed by the a d be detached for o ٥. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown CANCER ENDOMETRIAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy The certificate 1 ☐Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A
completely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHARLES ST. 841TE 4105 BALTIMORE, MD 21204 DOBERMANIMO 31. Date filed (Month, Day, Year) State Registrar JUL 0 8 2009

Baltimore, Maryland 21215-0036

			Plea						delible Ink						ible.		
	-	For State Registrar		S	tate of	Mar	yıand		artment of <i>rtificate of</i>			-	-	ne No. 2 (110	21	768
		1. Decedent's Name	e (First, Middle	e, Last)	_							2. Date of De	ath			3. Time o	f Death
Physicia /Medica		Shirley	Este1	le Wi	1son							July	1	Day 20	009	7:05a	M
Examine	er	4a. Facility Name (1.		-					4b. City, Town, Westmi					4c. County Carro	y of Death		
Funeral Director		5. Social Security N 213-28-46		6. Sex		7. Age <i>(l</i>	in yrs. las	st birthday) Yrs.	If Under t Year Months Days		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da Aug 26	iv. Yea	930	9. Birth	place (State ntry) MD	or Foreign
D	ŀ	Usual Residence of										Aug 20		930			
larytar i show	ě	10a. State MD	10b. County	11		11		Town or Lo riott	sville							10d. Inside C 1 □ Yes	ity Limits 2 ∐X No
with the N 3a or 28a-i	I Director	10e. Street and Nur 7104 Me1	mber		y Way	7		11000	10f. Zip Code 2110	4	·			Citizen of	What Cou	ntry?	
al', o	by Funeral	11. Marital Status 1 □ Never Marri 3 ★ Widowed	ied 2□ Mari	12.	Was Deced Armed For 1 ∐Yes If Yes, Giv Year or Da	dent Everces? 2 XVo	er in U.S.	13.	Was Decedent of If Yes, specify Cu			ecify Yes or No Rican, etc.))-	Bla	ce - Ameri ack, White, fy: Whi		
72 hou natura	eted	(Spec	15. Deceden	t's Education	on ompleted)			16a. Dece	dent's Usual Occu	ipation	most of work	ina	16b.	. Kind of B	Business/In	dustry	
within iene.	duc	Elementary/Seco		Ť	College (1-	-4or 5+)			kind of work done DO NOT use retire patcher	ed)		9	С	ommuı	nicat	ions	
uld be filed Aental Hygirked other rked other tic event, I	To Be Completed	17. Father's Name Howard		,	sterma	an			1			e (First, Middle Belvin					
12 shou h and h 7 is ma trauma		19a. Informant's Na							ng Address (Stree								1104
t Healt f Healt tem 2	ŀ	Karen Mar 20a. Method of Dis		ugnte	er)	Т	20b. Pla		osition (Name of matory or other plant			Date				own, State	.1104
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Departit. Departit Importit any inj		21. Signature of Fu		Licensee	ento	o x x	_		2. Name and Add							Chape	1
		23a. Part 1. Enter t) - 1				e death.		ter the mode of dy					21/84	+	Approxima Interval Be	ite tween
Physician		Immediate Cause disease or condition resulting in death)	(Final	a	Lune	g (one	V								Onset and	
/Medical Examiner					Due to	as a c	onseque	nce of):									
cuted nd ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate erlying injury s	D	Due to (d	or as a c	conseque	nce of):									
be icia our		resulting in death) l	Last		Due to (or as a c	onseque	nce of):									
The law requires that the death certificate ate has been signed by the attending phystoage 2 should be detached for use as the land.	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	23c.	If yes, outo 1 Live b 4 Pregn 9 Unkno	irth 2[ant at tir	Fetal d	death 3	☐ Ectopic pregnal	псу					ate of delivionth	very Day	Year
es the igner	۾	Part II. Other signit	ficant conditi	ons contrib	outing to de	ath but r	not result	ing in the ι	ınderlying cause g	iven in P	art I.	_		co use cor		the cause of	
he law require e has been si ige 2 should b	Completed											24a. Was auto perfo	psy ormed	?	prior to co death?	opsy findings ompletion of	s available cause of
	Be Co	25. Was case refer	red to medica	1						26. P	lace of Deat	1 □Yes h (Check only o	2 📶	No	1 ☐ Yes	2 (No	
Physician: this certific ral director,		examiner? 1 ☐ Yes 2 	No	Hosp	1 🗆 11	<u>'</u>		R/Outpatie	nt 3 □ DOA O	ther: 4 [Nursing Ho	ome 5 Res	idence	6 X O	ther (Spec	in hosp	sice
D 0 0	tlon:	27. Manner of Deat 1 Natural 2 Accident	th 5 □ Pendir investi		28a. Date o (Mont	of Injury h, Day, Y	/ear) 2	28b. Time o Injury	W	uryat ork? ⊒Yes 2	2 🗆 No	28d. Describe	how ir	пјигу осси	rred		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification: To	3 Suicide 4 Homicide	6 □ Could determ		28e. Place buildir	of Injury ng, etc. (- At hom (Specify)	ne, farm, st	reet, factory, office	1		28f. Location (City or To			ber or Rui	al Route Nui	mber,
Hospite Hospite Funera tely fille	Medical (29a. Certifier (Check Dily)			: On the ba	asis of ex	xaminatio		th occurred at the nvestigation, in my								(s)
To the within 2 To the comple	Mec	29b. Signature and	I title of certifie	r	and mann	iei statei	u		29c. Licer	nse numb		The state of the	29d.	Date sign	ed (Month	Day, Year)	
41		30. Name and addr	ress of person	who comp	leted caus	e of deal	th (Item 2	23a) (Type		Mi	N(1F)	1 Mil	2	115	7		
Stat	te	31. Date filed (Mon	nth, Day, Year)	0000	3. Re	egistrar's	Signat	re 1	white the		3.0						
Registra	ar	J	UL 08	2009	cen	wa	A.	190									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 200

Months

10f. Zip Code

1 ☐ Yes 2 🗖 No

7. Age (In vrs. last birthday

63

10c. City, Town or Location

BALTIMORE

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

BALTIMORE

21212

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Days

Physician /Medical Examiner

DEORGIE

Social Security Number

10e. Street and Number

10a. State

MD.

11. Marital Status

Director

Funeral

ģ

Completed

Be

ဂ္

Examine

Physician/Medical

≥

Completed

Be

Medical Certification: To

217-40-5892

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

N/A

1 X M 2 □ F

12. Was Decedent Ever in U.S. Armed Forces?

1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 2 XNo

4809 MIDWOOD AVE.

4809 MIDWOOD AVE.

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

Funeral Director

show it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Examinat must be notified at 1 and 2 should be Health and Mental

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

Physician /Medical **Examiner**

as the burial-trai attending physician for use as the buria been signed by the should be detached has

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, ours after death.

Jeral Director: After this certificate iffiled in by the funeral director, page Hospital or Attending Physician: within 24 hours a completely the

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -9--0-GENERAL MOTORS ASSEMBLY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLYDE NICHOLSON ROSIE WASHINGTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONIA WASHINGTON (WIFE) 4809 MIDWOOD AVE. BALTIMORE, MARYLAND 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Gemation Removal from State 4 ☐ Donation 5 Other (Specify) KING MEMORIAL PARK 7-11-2009 BALTIMORE, MARYLAND D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. ervice Ligenses ONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia for cause (Final disease of condition resulting of death)

a.

Due to (or as a consequence of the consequen Due to (or as a consequence of) Sequentially list conditions, if any, leading to induction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 DINO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2040

Month

Day

Were autopsy findings available

3 ☐ Probably

prior to completion of death?

8:30a

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

4 Unknown

1 X Yes 2 No

MARYLAND

14. Race - American Indian,

Black White, etc.

Specify: BLACK

4c. County of Death

10g. Citizen of What Country?

USA

Date of Birth (Month, Day, Year)

7-29-1945

N/A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 08

5601 Loch Raven Blud Baltimore MD 21239 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 20AM **Physician** WILLIAMS IHELMA 00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FUTURECARE IRVINGTON BALTIMORE 9. Birthplace (State or Foreign If Unc 8. Date of Birth Month Day Year 8-18-1926 7. Age (In yrs. last birthday) **Funeral** Months Days SOUTH CAROLINA 1 □ M 2 🖫 F 83 212-34-0983 Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location show 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar ment be inclined at ty∏Yes 2 □ No Director BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA Funeral 21217 931 BROOKS LANE 1st_FLOOR Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 🔀 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ပ CHARLIE HUNTER VERMELL THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and :
Department of Health
Important: If item 27
any Injury or other tr.
once. VERMELL POWELL-HAWKINS (DAUGHTER) 931 BROOKS LANE 1st FLOOR BALTIMORE, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation /5 □ Other (Specify) MT. ZION CEMETERY 7-10-2009 BALTIMORE, MARYLAND Trai Sent Selection See JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE KEART **Physician** MONTHS Medical Due to (or as a consequence of): Examiner THEROSCLEROTIC CARDIOVASCULAR DISEASE YISARS Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ☐Yes 2 No ed by the a 9 ☐ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 Tes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv perform 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation after death. 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar ERINEUTAWST. # 407

cumor.

32. Register's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dward J. Zisk	1	Sta - For State	ite of Maryla	nd / Depa	rtment of l	Health Death	and	Menta	i Hygiene	Da-	2	009	2177
Physicia		Registrar 1. Decedent's Name (First, Middle	,Last)						2. Date of				ne of Death
ledical Examir		Edward Josep							Month June 2	6, 200	09	02	229 hrs
		4a. Facility Name (if not institution	, give street and nur		4t	. City, Tov		cation of I	Death		4c. County of		
A.		12851 Ocean Gateway				Ocean			la a i	r Di-ul- (Worceste		/State or
Funeral				7. Age (In yrs. la	ast birthday)	If Under Months		If Under 2 Hours	Min		MM/DD/YYYY)	Foreign	
Director		197-58-6364	1 X M 2 F	40	Yrs.	Morraro	50,0		JAN	12,	1969	Country)	PA
Å	-	Usual Residence of Decedent 10a. State 10b. County		Inc. City	Town or Locatio	ın.						10d.	Inside City Limits
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daryland 28a-f show	힐	MD Worces 10e. Street and Number	ter	oce	an City	10f. Zip C	ode.			10a.	Citizen of Wh		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f sho ir traumatic event, the Medical Examiner must be notified at once.	Director	12731 Pony R	est Lane			218				US			ļ
ith the		11. Marital Status		edent Ever in U.	S. 13. Was	Decedent	t of Hispa	anic Origin	? (Specify Yes	r No-	14. Race	- American Ir	idian, Black,
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72 ho	ete	Elementary/Secondary (0-12)	College (1	-4 or 5+)	Plumber	st of worki	ing life. L	JO NOT U	se reurea)		Constru	etion	
036 ithin 72 rne. r than	Complete	10			Promper								
5-0 Hed w Hygic		17. Father's Name (First, Middle,	Last)						Name (First, Mic		iden Surname)	
21215-0036 hould be filed within 72 nd Mental Hygiene. is marked other than tire event, the Medical	o Be	Edward Zisk	in (Time Deine)		10h Mailing	Address			Leen Pri er or Rural Route		er City or Tow	n. State. Zip	Code)
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Baltimore, permit. Pages 1 at Department of He Important: If ite	1	4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:		ro Crem	ama and A	ddrocc	of Encility	6/29/09		<u>Baltim</u>		D
Baltimo permit. Page Department of Important: injury or oth	1 4	21. Signature of Fulleral Service)/	MU DLII	Cre	mati	on S	ocie	ty of Ma 1 Baltin	ryl	and, Ir	1C.	
Physician	-	23a. Part I. Enter the disease, or	emplications that of	aused the death	. Do not enter th	ne mode of	dying, s	such as ca	rdiac or respirato	ry arres	t, shock, or he	art Ap	proximate Interval etween Onset and
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Box 68760 e death certificate b the attending physical for use as the bu	sician/Me	IF FEMALE; 23b. Was decedent pregnant in the		outcome of preg		tal death	3	Ectopic	pregnancy		23d. Date o Month	Day	Year
certi n certi ending use as	ciar	past 12 months?		nant at time of d		her (Spec	-						
BOy e death the att	Physi	1 Yes 2 No 9 Uni	a _ Oliki										
के के के चि	by P	Part II. Other significant condit	ions contributing t	to death but not	resulting in the L	underlying	cause gi	iven in Pa					cause of death?
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Division of Vital Records, onts and arequire outs after death. Beral Director: After this certificate has been sifiled in by the functal director, page 2 should be	Certification:		ld not be	ce of Injury - At I			, onice b	unung, eu	or T	own St	ate)		ge , Ocean City ,
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To the Hospita within 24 hours To the Funeral completely fille	Medical	(Check only one) 2 ✓ Medical Exa	miner: On the basis	of examination	and/or investiga	tion, in my	opinion	, death oc	curred at the time	, date a	and place, and	due to the ca	iuse(s)
7 5 1 1 1 1	Mec	29b. Signature and title of certific	and manner	stated.				e number			29d. Date sig		
		Mayorte Mr	16110				0.0.1	M.E.			June 27, :	2009	
		30. Name and address of persor	who completed car	use of death (Ite	m 23a)			_		_			
		Margarita Korell MD.	Assistant Me			enn Str	eet, B	altimore	e, MD 21201				
	tate	31. Date filed (Month, Day, Year)		Registrar's Signa	ture do	Kal	-						
Reais	Terr.	.1111 0.8	7009 1/2	neur ,	a. Allan								

Naryland 21215-0036

/sicia	an	1 - State Registrar 1. Decedent's Name (First, Middle, Las Olga L. A:		ertificate of Death	2. Date of Death Month June 20	Day Year	3. Time of Death 10:00 p					
ledic amin	al	Olga L. A: 4a. Facility Name (If not institution, give 2137 Hidden Vall	street and number)	4b. City, Town, or Location of Dea	th 4	4c. County of Death Monto	gomery					
eral ctor		5. Social Security Number 6. Security Number 578-58-5346 11	7. Age (In yrs. last birthda M 2 F 90 Yrs.	Months Days Hours Min		9. Birthp Coun 1919 Per	lace (State or Forei try) u					
offind at	Director	10a. State 10b. County Maryland Mon 10e. Street and Number	tgomery Silve	Location er Spring 10f. Zip Code	100	Citizen of What Coun	0d. Inside City Limi 1 ☐ Yes 2★☐ N					
net De		2137 Hidden Val		20904		Peru						
any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☑ Yes 2 ☐ No Specify: P€		14. Race - Americ Black, White, 6 Specify: Whit	etc.					
ie Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	College (1-4or 5+) (Gi	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired) amstress	orking	Kind of Business/Ind Tailoring	dustry					
itic event, 🏻	To Be Co	17. Father's Name (First, Middle, Last) Alfredo Llaque	566		ame (First, Middle, Maid							
her trauma		19a. Informant's Name/Relationship (7 Alfredo Aris/Son	2137 I	ailing Address (Street and Number or F Hidden Valley Lane,	Silver Sp	ring, MD 2	20904					
njury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Metropol:		ne 24, 2009 A	Location - City or To	Virgini					
any I		21. Signature of Funeral Service Licens	certo	22. Name and Address of Facility Francis J. Collins 500 University Bly	Funeral Hord. W., Sil	ome Inc. ver Spring	,MD 2090					
ian cal ner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aortic Stenosis Due to (or as a consequence of):										
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as the bu	Wedical	IF FEMALE:	d				41					
tached for Use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year					
o e o	þ		ontributing to death but not resulting in the Failure, Coronary		23e. Did tobacc	co use contribute to the	ne cause of death? pably 4 🗌 Unkno					
Jage Z	Completed				24a. Was an autopsy performed 1 □ Yes 2 □	prior to co	psy findings availa mpletion of cause 2 No					
rai uirector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏲 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor	eath (Check only one) Home 5 Residence	e 6 □Other (Specia						
completely lilled in by the funeral director,	Certification: To	27. Manner of Death 1 💆 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	e of y 28c. Injury at Work? M 1 \[Yes 2 \] No	28d. Describe how in	njury occurred						
med in by		4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify) ysician: To the best of my knowledge, de		City or Town, St							
ompletely	Medical	(Check only one) 2 Medical Exam 29b. Signature and title of perfifier	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death oc	curred at the time, date	and place, and due to Date signed (Month,	o the cause(s)					
		> Calmet	ros S. Jama	D41034	6	122/09						
	-	30 Name and address of person who	completed cause of death (Item 23a) (T/p uria 128 Lubranc	e Print)								

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			Registrar 1. Decedent's Name (First, Middle	a Last)		OCI		Dealii	2 -	Date of Dea	Reg. No.		3. Time of	Death 3
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F	uneral		5. Social Security Number		ge (In yrs. last bir	rthday)	If Under 1 Year	If Under 24		Date of Birt Month, Da	th 9. Birthplace (State or Foreign Country)			
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Mar d2sh th and	Important: If Item 27 Is marked any injury or other traumatic ev once.		19a. Informant's Name/Relations				Address (Street							
6, 7 1 and Healt	ther 1		Lillian Recant 20a. Method of Disposition	Ames/ Spous			Gracefie		#509 Date	H-S,		er Spri)
riges of of	or o		1 ☐ Burial 2 🖺 Cremation		cemetei Nation	ry, crema	ition (Name of atory or other place	ce)		000		-		
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To the Hospital or Attending P within 24 hours after death.	ely fill		Check only 2 Medical	g Physician: To the best Examiner: On the basis of	of my knowledge	e, death	occurred at the ti	ime, date and	place, and	due to the	cause(s) an	d manner as s	stated. o the cause(s))
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	Registra	ar	JUN 23	2009 Ceraus	J	par	Ked							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Day Rebecca Ann Abdou 2749 M 2009 Lynn /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4c 4b. City, Town, or Location of Death Examiner Southern CLINTON Mare 9. Birthplace (State or Foreign Country)
Anchorage, Alaska If Under 1 Year | If Under 24 Hrs. 6. Se 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2 🕶 F 32 19, May 1977 Director 579-13-2563 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes ZXNo Director Charles Waldorf Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20601 2130 Marbella Drive Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 2 Specify. White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other that any Injury or other traumatic event, I'm once. 12 Retail Program Supervisor Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be S. Deemer Barbara **Pastos** William G. မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 Marbella Drive, Waldorf, MD William G. Pastos - Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 22,2009 Clinton, MD Lee Crematory 21. Signature of Funeral Servi 22. Name and Address of Facility Lee Funeral Home, INc. 5633 Old Alexandria Ferry Rd, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest ArTeriosu Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Physician/Medical Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. NO 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊟ Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

BB5

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, 32. Registrar's Signature Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

29d. Date signed (Month, Day, Year,

		Please	State of Mai		Depar	tment of	Health and I	-		egible	e.		y and jour
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he Ho in 24 h he Fui pletel)	Medical	(Check only 2 Medical Examone)	niner: On the basis of e and manner state		and/or inve	estigation, in n	ny opinion, death occi	urred at the time,	date and p	lace, and	I due to the	cause(s)	
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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 3:30P Dorothy Louise Bucklin 20, 2009 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Lorien Mount Airy Mount Airy 8. Date of Birth (Month, Day, Year)
Sept. 22, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours Months 91 1 M 2 W Maryland 220-46-8041 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Carroll Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21771 713 Midway Avenue - Apt. 206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No White Specify: ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 Is marked other i any injury or other traumatic event, <u>the any injury or other traumatic event</u>, <u>the</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Marie Bond James Day Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Robert Bucklin - Son P.O. Box 5801, Derwood, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Constion 5 ☐ Other (Specify) Pine Grove Cemetery June 23, 2009 Mount Airy, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Puneral Service Licenses nover 20872 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed burial-trar Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria pe Physician/Medical 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 Mo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Hospital or Attending Injury 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. Liçense number 29d. Date-signed (Month, Day, Year) 29b. Signature and title of certifier ute of death (Ite 4 K3 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16 2009 1 **Physician** 5:30P M Robert Lorring Beam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4198 Garnet Dr. Frederick Middletown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day 1953 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) GA Min 436-86-3706 **™** M 2 F 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a first first first from the fraction once. MD Frederick Middletown 1 ☐Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4198 Garnet Dr. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1 9 7 2 − If Yes, Give Year or Dates: 1975 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2本 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer electrical science 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Simmons Robert Leon Beam ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4198\ Garnet\ Dr.,\ Middletown,\ MD\ 21769$ 19a. Informant's Name/Relationship (Type. Print) Nancy Beam (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ☑ Cremation 3 ☐ Removal from State 5 ☐ Other (Stepity) 1 ☐ Burial 2 ☐ Cremation Smithsburg Crematory6/18/2009Smithsburg, 4 ☐ Donation Donald B. Thompson Funeral Home POB 18, Middletown, MD Approximate Interval Between Onset and Death Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseas Indition k **Physician** HOUN diseas ndition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by MECCITA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?

1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

|Cint and Day, Year) 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

610 Registrar's Signatu

Brunswick, MD 21716

29d. Date signed (Month, Day, Year)

29c. License number

AUJ

22037

			For State Registrar	State	of Marylan				ealth a	and M		jiene	009	217	80
	3		Decedent's Name (First, Middle	, Last)			_				2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physicia /Medic		Emma Stanley	Burroughs	3						June	13,	2009	9:30	A. M
6	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City	Town, or	Location o	f Death			ounty of Deat	h	
		10	Genesis Health	Care of	LaPlata			aPlat				Ch	arles		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21 ☐ F	7. Age (In yrs.		If Under	r 1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	9. Birti	nplace (State o untry)	or Foreign
n	Director		213-14-7609	10 M 2 <u>A</u> 1-	9.	5 Yrs.					09/02/	1913		MD	
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside C	ity Limits
	f eho	ō	MD Princ	e George'	. For	rt Was	hinat	on						1 ⊠Yes	2 🗌 No
	28a-	Pect	10e. Street and Number	e George	5 10.	LL Was		p Code				l 0g. Citize	en of What Co	untry?	
	Sa or	<u>-</u>	1020 Centennia	1 Drive				20744					USA		
	ne 2	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U.	S. 13.				gin? (Sp	ecify Yes or No- Rican, etc.)	14	. Race - Ame		
က	after or its	Ē	1 Never Married 2 Marr		2 🔼 No				in, Mexican Specify:	i, Puerto	Hican, etc.)		Black, White		
ğ	rali, c	Ď	3 ¼Widowed 4 ☐ Divorced	If Yes, G Year or	Dates:		1 1 1 42	2121110	зреспу.				B]	Lack	
21215-0036	be filed within 72 hours after death with the Maryland and Hygiene. and Hygiene. and thysine. and other than "natural; or items 23a or 28a-f show event, the Madical Examinar must be notified at	Completed	15. Deceden (Specify only highe	t's Education)	16a. Dece (Give	kind of w	ork done o	during mos	t of work	ing	16b. Kind	d of Business/	Industry	
2	hen.	ldu	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT		1)			77	1		
2	led w lygier her tl		UNK 17. Father's Name (First, Middle,	/ antl		Food	Serv	ice	18 Moths	ar's Nam	e (First, Middle,		oital _		
anc	ntal h	Be	David Stanley	Lasty							Jones		2		
Ž	should be tand Mental is marked o	2	19a. Informant's Name/Relations	hin (Type Print)		19h. Maili	ing Addres	s (Street			al Route Numbe	r. City or	Town, State, 2	Zip Code)	
<u>8</u>	id 2 s Ith an 27 ie 1 rau		Clarence J. Sta		how						t. Wash				
Baltimore, Maryland	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked eny injury or other traumatic esone.		20a. Method of Disposition	инсу/ пер		Place of Disponentery, cre	osition (Na	me of	at hi		Date		ation - City or		
e E	Page: ent of nt: Iff in ry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Dopation 5 ☐ Other (S		n State	ethel				6/20	/2009	Cam1	bridge	MIX	
Ħ	mit.		21. Signature of Funeral Service	7.57	, ,	2	2. Name a	and Addre	ss of Facilit	y Str	ickland	Fune	eral Se	ervices	
m	Depa Impo eny i	17	Okie D.	Strull	and	6	500 A	11en	town	Rd.,	Camp S	pring	gs, MD	20748	
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that	caused the deat	h. Do not en	iter the mo	de of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximatinterval Bet	tween
	Physician		Immediate Cause (Final disease or condition	Adva	nce Athe	eroscl	eroti	-C						Onset and Years	Death
	/Medical		resulting in death)		o (or as a conseq		0100.							1	
	Examiner		Sequentially list conditions	b. Diab	etes Mel	llitus			_					Years	
	sit sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_	o (or as a conseq	uence of).								**	
	and and III-tran	Examiner	that initiated events resulting in death) Last	C.	ntia o (or as a conseq	uence of):				_				Years	
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Вох	anding use	2	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		∏Estopia:					23	3d. Date of de	-	
œ.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ∏Feta gnant at time of d		□Ectopic □ Other (s						Month	Day	Year
P.O.	that the death certific ed by the attending p detached for use as	Physician/Med	9 Unknown												
	Pe Pe	by F	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the i	underlying	cause giv	en in Part I	l.				o the cause of robably 4X	
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Records,	alaw hasb e 2 st	Completed									24a. Was autop		24b. Were a prior to death?	utopsy findings completion of	available cause of
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o	ding th. Afte	tlon	1 XNatural 5 ☐ Pendii 2 ☐ Accident investi	9	e of Injury onth, Day Year)	Injury	М	28c. Injur Wor 1 🗌	rk? Yes 2. ☐	No					
Division	Attending r death. ector: After by the fune	Ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ce of Injury - At h	ome, farm, si	treet, facto	ory, office			28f. Location (S		Number or A	ural Route Nur	nber,
ă	s afte	Certification:	4 Hamicide	bui	lding, etc. (Special	ry)					City of You	vii, Siate)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 ☑ Certifyii (Check only 2 ☐ Medical	ng Physician: To t Examiner: On the	he best of my kno	owledge, dea	ith occurre	d at the tie	me, date ar	nd place	, and due to the	cause(s) a	and manner a	s stated. e to the cause((s)
	the H in 24 the F	edi	one)	and m	anner stated.										
1	To To	Σ	29b. Signature and title of certifie	. \	\			Licens	e number	15	0	1	signed (Mon 3/09	th, Day, Year)	
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	211	1	30. Name and address of person						٠ د ٦		20602				
	Sta	ite	George Wathen 3 31. Date filed (Month, Day, Year		15 Pembro Registrar's Signa	ature		=, Wa	ildori	, MI	20603				
	Registi		31. Date filed (Month, Day, Year JUN 2 4 20	109 Jane	In B.	bar	Las								

Physician /Medical Examiner **Funeral** Director Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is ust be neithed at any injury or other traumatic event, the Medical Examiner is used by a pince. Director Funeral BUCKMAN, Johnny 3altimore, Maryland 21215-0036 Be Completed by Pages 1 and 2 should be ဂ္

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June 20 2009 Johnny W. Buckman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Doctors Hospital Prince George's Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 19, 1949 Birthplace (State or Foreign Country)
 C 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) June DC 60 247-84-4829 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Greenbelt Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20770-7005 6510 Lake Park Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married African American 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintence Manager Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johnny Buckman, Jr. Annette Felder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 908 Alabama Ave. SE Washington, DC 20032 Terrace Buckman/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 27, 2009 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony Memorial 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral Service 0 4001 Benning Rd. NE Washington, DC 20019 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumenil /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if my leafing to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Eneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed' 1 ☐ Yes 2 Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 2 ER/Outpatient 3 DOA 1 Tes Inpatient Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name and address of person models (12 abeth Fasi Ka, MI). 8118

Data filled (Month, Day, Year) 32. Registrar's Signature 8118Good Luck Rd., Lanham, MD. 31. Date filed (Month, Day, Year) State JUN 2 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State State Registrar		rtificate of Deati			leg. No. 2	009	21782
ı	Physicia	an	Decedent's Name (First, Middle, Last) JOYCE	BARRE	7TT		2. Date of Dea Month JUNE	Day	Year 2009	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	DAKKI	4b. City, Town, or Location	n of Death	JUNE		ty of Death	00:11
N. A.			PRINCE GEORGE'S HOSPITAL	(-11:4: (-)	CHEVERLY If Under 1 Year If Under	er 24 Hrs.	O Date of Birth			ORGE Solace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1 □ M 2 □	yrs. last birthday) Yrs.	Months Days Hours		8. Date of Birth (Month, Day OCT 2	(Year)	Coui	SHINGTON, DC
	yland how			. City, Town or Lo	cation				1	0d. Inside City Limits
	Ba-fs	ecto		ITCHELLV				10- Citi	5 Mile at Carre	1 X Yes 2 □ No
	h with th	al Dir	1902 WEATHERBOURNE COURT		10f. Zip Code 20721			10g. Citizen o USA	yvnat Cour	ntry :
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. do other than "natural", or items 23a or 28a-f show event, if a M-sirel Examirst must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hispanic (fYes, specify Cuban, Mexic ☐ Yes 2 ☑ No Speci		cify Yes or No- lican, etc.)		ace - Americ lack, White, cify: BLA	etc.
15-0	72 ho "natur	leted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during m	ost of working	g	16b. Kind of	Business/In	dustry
121	e filed within al Hygiene. I other than " went, It a Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) RSE ASSISTANT			PRIVA'	ΤE	
pu	be filed stal Hygi d other event,	Be C	17. Father's Name (First, Middle, Last)				(First, Middle,	Maiden Surn	ame)	
ryla	2 should be and Menta is marked araumatic ev	2	JOSEPH VANZEGO	10h Mailin	ng Address (Street and Nun	ERTHA	SHAW Bouts Alumba	r City or Tou	in State 7ii	Code) 1074
Ma	alth an 27 is r		19a. Informant's Name/Relationship (Type. Print) JOE L. BARRETT/HUSBAND		WEATHERBOURN					
Baltimore,	es 1 ar of Hea fitem rothe				sition (Name of natory or other place)	Da	ate	20c. Locatio		
ţ	t. Pag tment tant: i	-	4 Donation 5 DOther (Specify) M		NS CEMETERY		2009 G		-	MARYLAND
Baj	permit. Pages 1 and 2 should be Department of Health and Menha Important: if item 27 is marked an injury or other traumatic every	•	21. Signature of Fuller ervice License		2. Name and Address of Fac 7474 LANDOVE	-				
ı	Physician		23a, Part 1. Enter the disease, or complications that caused the caused the cause on each line. Immediate Cause (Final disease or condition) FATAL CAR	death. Do not ent	er the mode of dying, such					Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death) a. FATAL CAP Due to (or as a cor				-			
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68760,	rificate be executed by physician and as the burial-transit		resulting in death) Last Due to (or as a cor HYPERTENS							
	rtificat ing phy as the	Medical	IF FEMALE:							
O. Box	that the death cer led by the attendin detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of properties of the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			. 1	Date of deliv Month	oery Day Year
rds, P.	The law requires that the ate has been signed by the age 2 should be detache		Part II. Other significant conditions contributing to death but not OSTEOPOROSIS	t resulting in the u	nderlying cause given in Pa	irt I.				the cause of death?
of Vital Records,		Completed by								opsy findings available ompletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor		(Check only or			
on of	ling Phys After this uneral dir	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Yea	2 XER/Outpatier 28b. Time of Injury	IL SLIDOA 4LI	2	ne 5 Resid			ify)
Division	I or Attending after death. Director: After d in by the funer	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, str pecify)			8f. Location (S City or Tow	Street and Nu vn, State)	mber or Rui	ral Route Number,
_	Hospita 24 hours Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one and manner stated.	y knowledge, deat mination and/or in	th occurred at the time, date overstigation, in my opinion, o	e and place, a death occurre	and due to the ed at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	M (29c. License numbe	er		29d. Date sig	ned (Month	Day, Year)
			y. Windell M Conn	oll Mode	D29654			JUNE	23, 2	2009
R	15		30. Name and address of person who completed cause of death J. WENDELL MCCONNELL M.D. 1		· ·	LARGO,	MARYLA	ND 207	74	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 5 2009 Annual 32. Registraries	Sign ture			-			

DHMH 17 Rev 1/2001

		1- For Amend Items State of Maryla 23aPtII,28d	and/Depa per me <i>Cer</i>	rtment of He 2893,0772 filicate of De	alth and Me eath	ntal Hygie Reg.	ne No2009	21783
Physic	cian	1. Decedent's Name (First, Middle, Last)	Cornell		2.	. Date of Death Month	Day Year	3. Time of Death
/Med	lical	Lawrence	Cornell			June 18	3, 2009	03/5 M
Exam	iner	4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Lo			4c. County of Death Montgomes	rv
Funera		5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday)	If Under 1 Year I	f Under 24 Hrs. 8	. Date of Birth		place (State or Foreign
Directo	_		0 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye	1919 New	York
and		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	ation	· · -		1	0d. Inside City Limits
Maryli -f sho	į		thesda					1 □ Yes 2 No
r 28a	iro	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cour	ntry?
th with 23a o		9707 Old Georgetown Road #12	12	20814			USA	
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Medical Experiment matter at	hy Funeral Director			las Decedent of Hisp Yes, specify Cuban, □Yes 2 No	panic Origin? (Specif Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
2 hour			16a. Deced	ent's Usual Occupation	on	168	o. Kind of Business/Inc	dustry
hin 72 e. man "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	`life. D	kind of work done duri O NOT use retired)		1		
filed within Hygiene. other than "			Busin	ness Mange			Self Emplo	yed
intai H ed oth	å	17. Father's Name (First, Middle, Last) Harry S. Cornell		18	8. Mother's Name <i>(F</i> Mary Mil		den Surname)	
ar yre	٩	19a. Informant's Name/Relationship (Type. Print)	19h Mailing	Address (Street and			ity or Town, State, Zip	Code)
INICA nd 2 s alth ar 27 is r trau		George L. Cornell, Jr. / Son	1	Fairfax Ro			20814	00007
ss 1 a of Hear		20a. Method of Disposition 20b		ition (Name of atory or other place)	Date		c. Location - City or To	wn, State
Page ment ment annt: II		1 ILI bunar 2 L. Cremation 3 L. Bernoval from State 1	ational (Crematory	06/20/	09	alls Churc	•
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra	XIIX	21. Signature of Funeral Service Monses					er's Sons ash., D.C.	
		23a. Part 1. Enter the dise se, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	r the mode of dying,	such as cardiac or r	espiratory arrest		Approximate Interval Between Onset and Death
Physician /Medical	_	Immediate Cause (Final disease or condition resulting in death)	Plour	a/ ES	30910	77	0	p
Examiner	•	Due to (as a cons	equance of):	Keart	Carlo	(0		DME
2 pg . ±is	i de	Se yientially list conditions if any, leading to immediate cause. Enter Underlying	equence of):	î ./	,) ,		-\/ \m''	
fficate be executed physician and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cons	equence of):	T7C 5X	eno90	20 NG	, J. J.	0
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rtifica ng ph as th	Medi	IE EENAN E.			3		0	
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of the pregnant at		Ectopic pregnance Other (specify)	~10		23d. Date of deliver Month co use contribute to the contribute to	ery Day Year
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law re as bee 2 sho	Completed			TICATION APPRI	Jv=	24a. Was an	24b. Were auto	psy findings available empletion of cause of
	l e			CERIII		performed 1 Tyes 2	death? No 1 ☐ Yes	2 □No
lclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		00	6. Place of Death (C	Check only one)	· · · · · · · · · · · · · · · · · · ·	
Physician ral direct	12	1 Yes 2 □ No Prospital: 1 inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of		4 LI Nursing Home	5 Residence.	e 6 Other (Special	ý)
Attending Physician: It death. ector: After this certific. by the funeral director.	Certification:	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation) Injury	28c. Injury at Work? 1 ∐ Yes	s 2 No		Exacerbati Medical co	on of ondition
r Attendi er death. rector: A	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Countries)	t home, farm, stre	•	28f	Location (Stree	et and Number of Hara State) 9 7 0 7 3	al Houle Number.
ital or ral Dir led in	S		HOY		6	no cons	in RJ, 130	Lhesda mil
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ¢	edical	29a. C #tifier (*heck orh (e) **D ** Medical Examiner: On the basis of exam (e) and manner stated.	knowledge, death ination and/or inv	occurred at the time, estigation, in my opin	, date and place, and nion, death occurred	d to the cause at the time, date	se(s) and manner as s and place, and due to	stated. 2 0 15 o the cause(s)
To th To th	Me	29b. Signature and title of certifier		29c. License no	umber	29d.	Date signed (Month,	Day, Year)
6		Juna Vieure Tama		Dooh	5187/	Jun	ie 18, 2009)
		30. Name and address of person who completed cause of death (It			70-			
S	ate	Sima Nourani Zenuz MD 8600 010 31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature		Bethesda,	MD 2081	. 4	
Regis		JUN 23 2009 Sentus	1. par	مدا				

Registrar DHMH 17 Rev 1/2001

PRINTELLI CHEORGE Oblishog 0315

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 18, 2009 Year 10:24 P M Milton CHORVINSKY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Holy Cross Hospital If Under 24 Hrs. 8. Date of Birth Aug. 4, 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min Pennsylvania **1**926 1**火**□ M 2□ F 82 204-24-3364 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number United States 20852 6020 California Circle #102 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Forces: 1 □ Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify white Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Department of Elementary/Secondary (0-12) College (1-4or 5+) Mathematician/Statistician Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Simon Morris Chorvinsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20852 Rockville, MD 6020 California Circle, #102, Irma Chorvinsky, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/21709 1 Burial 2 Cremation 3 Removal from State Falls Church, VA King David Memorial Garden 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Frinaral Sq vice Licensee 401008 Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Years Heart Failure disease or condition resulting in death) Due to (or as a consequence of) Years Severe Cardiomyopathy Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 🗍 Unknown Incarcerated Hernia

Physician /Medical Examiner

Physician

/Medical

Examiner

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Item 27 i

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72 hours after death with the

Baltimore, Maryland 21215-0036

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Box 68760.

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After this certificate funeral director,

Division of Vital Records, To the Hospital or Attending Pr within 24 hours after death.
• To the Funeral Director: After t completely filled in by the funera

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											24a. Was an autopsy performed? 1 □Yes 2♥No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referre	d to medical								26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 🔼 N	lo	Hos	pital:	1 ☐ Inpatient	2 🔲 E	R/Outpatient	3 🗆	DOA	Other: 4 Nursing	Home	e 5 ☐ Residence 6	☐ Other (Specify)
27. Manner of Death 1 🙀 Natural 2 🖰 Accident	5 Pending investigation		28a.	Date of Injury (Month, Day, Yea		28b. Time of Injury	М	28c	. Injury at Work? 1 □ Yes 2 □ No	28	d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		28e.	Place of Injury - A building, etc. (Sp	At hon pecify,	me, farm, stree)	t, fact	ory, o	ffice	28	if. Location (Street and City or Town, State)	Number or Rural Route Number,
20a Cortifier	Cortifuing Ph	veic	ian:	To the best of my	know	vledne death (occurr	ed at	the time, date and place	ce ar	nd due to the cause(s)	and manner as stated.

D 0061887

June 18, 2009

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifie 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20895 10810 Connecticut Ave., Kensington, MD Ira Y. Rabin, M.D.,

State Registrar 31. Date filed (Month, Day, Year) 2009 JUN 23



			For State Registrar	State of Ma	aryland /	•	rtment of F tificate of a		nd Mental F	lygier Reg. M	000	10 2	21785
	Physic		1. Decedent's Name (First, Middle,	ANTY					2. Date of Month	Death	- U	Vear	Time of Death 2:45 PA
A CONTRACTOR OF THE PARTY OF TH	/Medi Examir		4a. Facility Name (If not institution, g	Lane			4b. City, Town, or Belts	ville	Death	F	RINC	of Death E GEO	RGES
	Funeral Director		5. Social Security Number 180-28-1743 Usual Residence of Decedent	. Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last t	birthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month, Sept	Birth Day, Yea . 9 , 1	918	Country)	(State or Foreign
	Maryland	tor	10a. State 10b. County	Georges	10c. City, To		ation Ltsville	e					Inside City Limits 1 □¥es 2 □ No
	th with the 23a or 28a ast be noti	al Director	10e. Street and Number 10463 Gross	Lane	I.		10f. Zip Code 207	05		10g. (U.S	hat Country?	
980	be filed within 72 hours after death with the Maryland ntal Hyglene. ad other than "natural", or items 23a or 23a-f show event, the Medical Exercities and the notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □Yes 2 No	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	Black	- American I , White, etc. Blac	
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	Page: nent o int: If		20a. Method of Disposition 1 □ 3 □ 1 □ Cremation 3 4 □ Donation 5 □ Other (Soe	cify)		al N	sition (Name of latory or other place) Aem Cem	6,	Date /22/09 - SNOWDE	Sa	andy		state 1 g, MD 1 E, P.A.
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P.O. Box 68760,	t the death certifi by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	2 Fetal dea		Ectopic pregnanc	у		-	23d. Date Mon	of delivery oth Day	y Year
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ivision	ding Phys n. After this funeral dir	Certification: To Be	examiner? 1 Yes 2 So 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could no determine	28a. Date of Inju (Month, Date)	y, Year)	. Time of Injury	28c. Injur Wor	er: 4 □ Nursi	28f. Location	esidence be how in	jury occurre	d	oute Number,
	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	Medical Ce		Physician: To the best caminer: On the basis o and manner sta	f examination								
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	<i></i>		30. Name and address of person who Deep Kykre	ti, M.D.	14201	. La	urel Pa	rk Dr	, Laure	1 ,	MD 2	0707	
E	Sta Registi		31. Date filed (Month, Day, Year) JUN 23	32 Registr	ar's Signature	40	des.						

			For State Registrar	State of	Maryla	nd / Depa <i>Cel</i>	artmer rtificat			and M		giene Reg. No.	200	21786
	Dharisi		1. Decedent's Name (First, Middle, La	est)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		James	Cox							June	19	2009	5:27 p ^M
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7			Pineview Future		- 4 - 4	- (4 b :- 46 - 4 - 1)	1	nton	If Under	24 Hrs. I	0. Date of Bir			Georges rthplace (State or Foreign
	Funeral		5. Social Security Number 6. S	sex 1.23¥M 2.□F	7. Age (<i>in yr.</i> 92	s. <i>last birthday)</i> Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Date 13)	av Year)	1 0	NC
	Director		237-28-7633 Usual Residence of Decedent		92			l			Julie 1	0, 17		110
	yland		10a. State 10b. County		10c. 0	City, Town or Lo	cation							10d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zij	Code				10g. Citize	en of What C	country?
	ath w	ra	1920 Oakwood St.					2074					USA	
	items	Funeral	11. Marital Status	12. Was Dece	ces?	U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori ın, Mexicar	igin? (Spen, Puerto	ecify Yes or No Rican, etc.))- 14	I. Race - Am Black, Whi	erican Indian, ite, etc.
36	rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes If Yes, Giv Year or Da	e		1 □ Yes	2 X No	Specify:			5	Specify: P	Black
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Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Pureral Service Lice	In m	4						Home of			11.6
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	4		30. Name and address of person who									. m	0010	
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DHMH 17 Rev 1/2001

09-04939 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Abdul M. Choudhry State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day June 22, 2009 CHOUDHRY 2330 hrs **Medical Examiner** ABDUL 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Wicomico Peninsula Regional Medical Center Salisbury 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Director 1960 050-84-6785 Country) nKistan 1XM 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No SALISBURY WICOMICO t Pages 1 and 2 should be filed within 72 hours after death with the Maryland tront of Health and Mental Hygene.
relatif If tean 27 is marked other than "natural", or items 23a or 28a-f shy conferrestment of the modified at once other reanmatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? Pakistan 2108 istury 14. Race - American Indian, Black Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes ASIGN If Yes, Give Year 3 Widowed 1 Yes 2 No specify: Divorced Specify: <u>8</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 10 Business 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAKINA B1B1 MUHAMMAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Blud Sa JAHANGIR ADIL CHOUDHR Place of Disposition (Name of cemetery, Date 1 N Burial 2 Cremation 3 N Removal from State crematory or other place) GUTRAT 4 Donation 5 Other Specify 22. Name and Address of Facility Aden Muslim Hur Woodbridge cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical a Multiple Gunshot Wounds Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available performed? death? ✓ Yes 2 No 1 🗸 Yes After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Jun 22, 2009 1 Natural Subject shot 2303 hrs 1 ✓ Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2513 North Salisbury Road, Salisbury, MD determined (Specify) Other (Gas Station) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

QC 3

31. Date filed (Month, Day, Year) 111N 2 4 2009

Theodore M. King, Jr., MD.

29b. Signature and title of certifier

Assistant Medical Examiner

32. Registrar's Signatur

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

June 23, 2009

State Registrar

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** June 20. 2009 11:30 A Joseph A. Clayton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Prince George's Prince George Hospital Center Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 1 X M 2 □ F Months Days Hours Min. ĎC June 26, 1939 215-36-2726 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 X Yes 2 □ No Director Lanham Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 United States 9011 Varnum Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🕅 Married Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Work Leader Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Joseph Clayton Bernice Henson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia Clayton/ Spouse 9011 Varnum Street Lanham, Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 25, 2009 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Landover, Md. 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lice 4001 Benning Rd. NE Washington, DC 20019 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shoot heart failure. List only one cause on each line. Immediate Cause (Final Exsangua disease or condition resulting in death) Due to (or as a cons. grence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Due to (or as a consequence of) Fata IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 🗆 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 □Yes 3 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ¥Yes 2□No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 3 Tarted 5 Pending investigation 1 Natural bleed from A-V 1 ☐ Yes 2 ☐ No 2 Accident

Physician/Medical

Funeral

Director

28a-f show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evat. in the termorthed at

2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or Items 23:

eimit. Pages 1 and 2 Lecartment of Health a important: If item 27 is ny Injury or other tra

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

law requires that the death certificate be executed attending physician and for use as the burial-transit signed by the atte peen has completely filled in by the funeral director, of or Attending Fafter death. Affer

6 ☐ Could not be

June 16, 2007 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1700 M

home

28f. Locatio (Street and Number or Rural Route Number, City or Town, State) 9011 Var Number, STreet, LANKAN, MARY

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and of death (Item 23a) (Type, Print) rson who completed cal

State Registrar

Medical

31. Date filed (Month, Day,

3 ☐ Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)



e Hospital

To the I within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Audrey Crawford 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3/4/36/14 NICOMICO eninsula Regionia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 04/02/1926 Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🛛 F 222-14-2208 83 Delaware Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Wicomico Delmar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21875 USA 8630 Ponds Edge Ct Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white ≥ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 legal secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever Emma Knight Henry Foote ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8630 Ponds Edge Ct., Delmar, MD 21875 Health a Jim Foote/son If item 27 or other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₽ Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/24/09 New Castle, DE Gracelawn Memorial 4 Donation 5 Dother (Specify) Park 21. Signature of Puneral Service Lice Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNOSEPSICO dal Physician | disease or condition resulting in death) /Medical Examiner elleren + Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 No director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1/ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the within 2

State Registrar

DHMH 17 Rev 1/2001

Medical

6 ☐ Could not be

determined

3 ☐ Suicide

29a, Certifier

4 Homicide

Name and a

29b. Signature and title of pertific

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 17:10 M 19 2009 JUNE **JAMES** BENTON CHILDERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 A M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Hours Days Months 82 NOV. 24, 1926 TENN. 265-22-4103 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the frequence Examiner must be notified at once. 10a State 10b. County 1XXes 2 □ No **Funeral Director** FENWICK ISLAND DELAWARE SUSSEX 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19944 USA 708 COASTAL HIGHWAY 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 X No Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) RETAIL OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mc CORKLE JULIA CLARA CHILDERS SR. В. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 708 COASTAL HIGHWAY, FENWICK ISLAND, DE. 19944 HELEN L. CHILDERS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/23/09 DELMAR, DELAWARE CREMATORY OF DELMARVA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22, Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Partl. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Idiapathic atte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No Dav 5 Other (specify) a 🗆 Hnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? Yes 2 2 No certificate ha 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? To the Hospital or Attending Pr. within 24 hours after death.

To the Funeral Director: After the Completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/19/2009 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Atif Zec Chan An Hand 00064120 Aut 9733 Hoffh Way Drive Berlin MD 21850 31. Date filed (Month, Day, Year) State אייא 2 3 **2009** Registrar

9/60:GO

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Baltimore, Maryland 2121

68760.

Box

P.0.

Records.

Vital

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Division

Childers, JAMes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 4:27 a^M John Causey 2009 June 19, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury 4104 Harvest Lane If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 71 07/12/1937 Maryland Director 219-34-3017 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be rediffed at 1 ☐Yes 2 XNo Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21804 4104 Harvest Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Mayes 2 No If Yes, Give Army Year or Date Army 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) construction builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathryn Willis Larry J. Causey Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4104 Harvest Lane, Salisbury, MD 21804 Charlotte Causey/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO MEMORIAL 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/23/09 4 Donation 5 Dother (Specify) Salisbury, MD Park 21. Signature of Funeral Service Liver PHOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancicahi **Physician** Canier resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): burial Box 68760. physician Physician/Medical the signed by the attending IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. □Yes 2□No g□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has performed certificate 1 ☐ Yes 2 🗷 No Division of Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Director: After this funeral To the Hospital or Attending Prywithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 047094

Registrar
DHMH 17 Rev 1/2001

State

1415

32. Pegistrar's Signature

5. DIVISION

SALISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN

VEL

31. Date filed (Month, Day, Year)

09-05189

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yssia Cage	State of	Maryland / Depar Cert	tment of I <i>ificate of I</i>		Mental H		200 g. No.	9 2179
Physician/	Decedent's Name (First, Middle,Last)	ary C	age			2. Date of Death	Dav Year	3. Time of Death 1548 hrs
	4a. Facility Name (If not institution, give st		4b	. City, Town, or Lo	ocation of Death		4c. County of Deal	h
Funeral Director	Memorial Hospital 5. Social Security Number 216-21-6537 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24Hrs	_	,	rthplace (State or Foreign ountry)
	Usual Residence of Decedent		Yrs.			li en o,	1300	
Maryland 28a-f show any d at once.	10a. state 10b. County MD Allegan	y 10c. City, 1	Cumb	erland				10d. Inside City Limits
the Maryland 3a or 28a-f sh otified at once		nue		10f. Zip Code	21502	10	g. Citizen of What Co US	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in Department of Health and Mental Hygiera in Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified a Lonce. To Re Completed by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? Yes 2 No Yes, Give Year	If Yes	Decedent of Hisp. s, specify Cuban, res 2 No	Mexican, Puerto		14. Race - Ame White, etc. Specify: Whi	rican Indian, Black,
5-0036 ed within 72 hours. tygiene. other than "natura he Medical Exami		highest grade completed) College (1-4 or 5+)	16a. Decedent's during mos	Usual Occupations Usual Occupa	on (Give kind of DO NOT use ret	work done ired)	16b. Kind of Business Frostburg	g State Univ.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica	Craig Cage				Carol	Moran		
MD 21 tid 2 should tith and Me m 27 is ma aumatic ev	2 19a. Informant's Name/Relationship (Type Craig Cage	father	19b. Mailing 812	Address (Street Memorial	and Number or Avenue	Rural Route Num Cun	ber, City or Town, Sta nberland	te, Zip Code) MD 21502
Baltimore, Permit. Pages and Department of Healt Important: If item injury or other tran	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	rematory or other	on (Name of cemer place) orial Park	etery,	Date 7/6/2009	20c. Location - City of Cumber	
Baltin permit. J Departm Importa	21. Signature of Funeral Service License	11.	22. Na		i Funeral H		and, MD 21502	
Physician 'Medical	23a Part I. Enter the disease, or complice failure. List only one cause on each Immediate Cause Final disease. a. E.	tion, that caused the death. In . Tremity Injuries	Do not enter the	mode of dying, s	uch as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
_xaminer	or condition resulting in death Du	e to (or as a consequence of)):					
ed Insit	Sequentially list conditions, If any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of	:					
ecuted and and transit	events resulting in death) Last Du	e to (or as a consequence of):					
0, e be execut ysician and burial - tra	UNPENDED	AMENDED						
ox 6876 ath certificat attending ph or use as the	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 er (Specify)	Ectopic pregn	ancy	23d. Date of delive Month	ery Day Year
P.O. Bost that the degreed by the edetached for the degree by the by the by Physical for the by Physical for the by Physical for the by Physical for the physic	Part II. Other significant conditions	ontributing to death but not re	sulting in the ur	derlying cause gi	ven in Part I.			to the cause of death?
rds, P.C requires that been signed hould be deta		·				1 Yes		autopsy findings available completion of cause of
of Vital Records, g Physician: The law require. ther this certificate has been signered director, page 2 should by						perfor 1 Y es	med? death'	?
Vital ysician: his certificator director	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	ER/Outpatient	140	of Death (Check Other Nurs		Residence 6 Ott	ner:
on of Vi ending Physi ath or: After this the funeral di		28a. Date of Injury Jul ^{(Month} Day, Year) Jul 1, 2009	28b. Time of In 1433 hrs	`	y at Work? es 2 ✔ No		now injury occurred to to auto collisio	n
Division o spital or Attending hours after death nueral Director: Aft y filled in by the fune		28e. Place of Injury - At ho (Specify) Major Road		, factory, office bu	uilding, etc.			Rural Route Number, City arage, Short Gap, WV
Di To the Hospital within 24 hours a To the Funeral completely filled		: To the best of my knowledg n the basis of examination ar	e, death occurr nd/or investigation	ed at the time, dat on, in my opinion,	te and place, an	d due to the caus at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
To with To con	29b. Signature and title of certifier	nd manner stated.		29c. License			29d. Date signed (M	Month, Day, Year)
	30. Name and address of person who con	moleted raises of doub (Hom	23a)	O.C.N	л.Е. —————		July 2, 2009	
	**************************************	npleted cause of death (Item Assistant Medical Exar		Penn Street	, Baltimore,	MD 21201		
Stat		32. Registrar's Signatu	A ba	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year O Month **Physician** 710 219 derc 06 200 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town or Location of Death **Examiner** alt Moryland impre MD more. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Age (In yrs. last birthday) Date of Birth (Month, Day, Country)
VIRGINIA onth, Day, Year) 11/01/1929 Months Days Hours 1 □ M 2**X** F Min. Yrs 425-28-5713 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if then 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Profice! Examiner must be notified an once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No MARYLAND DORCHESTER **CAMBRIDGE** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 107 MIMOSA DR. 21613 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. ģ Specify. 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN REYNOLDS GLENNIE CAMPBELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE E. THOMAS / SISTER 1248 SPRINGHILL RD., HANAHAN, SC 29410 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1XI Burial 2XI Cremation 3 Removal from State 7/2/2009 PARKWOOD CEMETERY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE. MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocard disease or condition resulting in death) /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or s a consequence of): that initiated even resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔼 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗆 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division of Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran the detached as been signed by the should be detached certificate has page 2 funeral director, After this thours after death.

uneral Director: A ely filled in by the fu within 24 hours a Hospital

Certification: To 29a, Certifier cal

(Check only one)

State Registrar

completely

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

225. Greene S

MD

21001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sankai O. 101

Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dav Year **Physician** LEROY D. CROGHAN 6/30/2009 12:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DORCHESTER MALLARD BAY CARE CENTER CAMBRIDGE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F 9/15/1941 67 PENNSYLVANIA Director 178-32-5357 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1 □Yes 2X No Directo **DORCHESTER VIENNA** MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2234 ELLIOTT ISLAND RD 21869 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced WHITE "natural", 1959 -1961Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, Ita. once. POLICE OFFICER LAW ENFORCEMENT 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EDWARD JAMES CROGHAN** DOROTHY (UNKNOWN) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAVID M. CROGHAN / SON 1018 ANNA BROOK PARK DR., O'FALLON, MO 63366 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/30/2009 CAMBRIDGE, MD MID SHORE CREMATION CENTER 22. Name and Address of Facility 21. Signature of Funeral MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final movithis **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has al director, page 2 a performe Yes 2 2 No 3-258 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Specify Specify Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Inpatient 27. Manner of Peath
12 Natural
2 Accident funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a
To the Funeral C
completely filled 1 TerrityIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical apd manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 18, Day 200 year JUNE 1454 **Physician** DOWNING JOE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOWARD Columbia Howard County Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Nov • 14 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F ,1940 Kentucky 403-52-9984 68 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evandrer must be notified at Yes 2 No ΚY Scott Georgetown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than ".... any injury or other traumati." U.S.A. 174 Scotland Woods Drive 40324 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 🌠 □ No Specify: Black Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Facility Manager Mantainence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Washington Raymond Downing, Sr ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 13201 Highland Road, Highland, MD 20777 DeAnna Thomas (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from-State Eyergreen Mem.Gdns 6/27/09 Lexington, KY 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sign ure of Funeral Service Licensed 246 N. Washington St, Rockville, MD 20850 2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. weeks Immediate Cause Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ER/Outpatient 3 ☐ DOA Medical Certification: To this Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner of Death After 1 Natural

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the form

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29c. License number 29b. Signature ar

29d. Date signed (Month, Day, Year)

30. Name and address/of person 22

State Registrar

			For State Registrar	State of I	Maryland		artment o <i>rtificate d</i>				jiene leg. No	2009	21796
	Physici	an	1. Decedent's Name (First, Midd							2. Date of Dea Month	-	Year	3. Time of Death
	/Medic		Rafael Alarco							June 2	20, 2	2009	3:35 p M
	Examin	er	4a. Facility Name (If not institution 4013 Glenrose)		er)		4b. City, Tow					County of Deat	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last	birthday)	If Under 1 Ye	ensino ear IfUn ays Hou		8. Date of Birth (Month, Day April 2		ontgome 9. Bird	hplace (State or Foreign
	Director		231-44-4055	1 ₹ M 2□F	88	Yrs.	IVIOTITIS D	ays Hou	JIS WIIII.	April 2	21,	1921	Mexico
	land ow		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, T	own or Lo	cation						10d. Inside City Limits
	a-f sh	ctor	Maryland	Montgomer	У	Ken	singtor	ı					1 □ Yes 2 🖰 No
	or 28	Director	10e. Street and Number				10f. Zip Coo			1		en of What Co	untry?
	sath w	Funeral	4013 Glenros		ant Fiver in 11 C	10.1	2089		o Origina /Cno.	oifu Vaa ar Na		SA 4 Boss Ame	ricen Indian
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rediffied at	by	11. Marital Status 1 ☐ Never Married Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	es? K iNo		f Yes, specify (xican, Puerto F	cify Yes or No- Rican, etc.) Can		Race - Ame Black, White Specify:	
5-0	72 hc	letec	15. Decede (Specify only high	ent's Education est grade completed)	1	(Give	dent's Usual Oo kind of work do	one during i	most of workin	9	16b. Kir	d of Business/	Industry
12	filed within Hygiene. yther than "	Completed	Elementary/Secondary (0-12)	College (1-4d 5+	or 5+)		00 NOT use re ld Psyc		rist		Ps	ychiat	ry
בַּ	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle					18. M	lother's Name	(First, Middle,	Maiden S	Surname)	
ylaı	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	으	Pastor Delga	ado ———————				Caro1	lina Al	arcon			
Maryland	d 2 shoth and the and 7 is m		19a. Informant's Name/Relation							Route Numbe			•
ē,	is 1 and 2 soft Health a item 27 is		Doris J. Delga 20a. Method of Disposition	ado /Wife	20b. Plac		Glenro sition (Name o natory or other		June	Kensing		MD 20 cation - City or	
E O	Pages ment of I ant: If ite ury or o'		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 💆 Other (3 □Removal from Sta Specify) entombi	116 1					2009	Silv	zer Spr	ing, Marylan
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service			F	rancard A	deress of E	lins	Funeral	Hon	ne Inc.	ng,MD 20901
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that cause only one cause on eac	sed the death. I	Do not ent	er the mode of	dying, suc	h as cardiac o	respiratory an	est,		Approximate Interval Between
3	Physician	ŭ i	Immediate Cause (Final disease or condition resulting in death)	a. Failure	e To Thr	ive							Onset and Death approx. 6
	/Medical Examiner		resulting in death)	Due to (or Dement:	as a consequen	ice of):							months
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68760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a consequen	ce of):							
687		edical		d									
P.O. Box	death ce e attendii d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal de nt at time of deat	eath 3	Ectopic pregr Other (specif				2	3d. Date of de Month	livery Day Year
	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant condit	_		-		given in P	art I.	23e. Did to	bacco us	se contribute to	the cause of death?
ord	w require s been si should b		Hypertension,	Coronary Ai	rtery Di	seas	e 			1 🗆 Y	es 2[No 3 P	robably 4X Unknown
Division of Vital Records,	Physician: The law rethis certificate has braid director, page 2 sh	Completed					-			24a. Was a autop perfor 1 □Yes	sy med?	prior to death?	utopsy findings available completion of cause of 2 □ No
=	rslclar s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	patient 2 ☐ ER	Outpation	* 3□ DOA	Other:		(Check only or		Other (0-	-15 A
0 ر	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of		b. Time of Injury		Injury at Work?		ne 5 X Resid 8d. Describe h			icity)
sior	endin eath. or: Af the fur	catio	- I ribolderit	tigation	Day, rear)	Hijury		1 ☐ Yes	2 □No				
Ω	To the Hospital or Attending P within 24 hours attended. To the Funeral Director: After to completely filled in by the funera	Certification:	4 Hornidae	mined 26e. Flace of building,	Injury - At home , etc. (Specify)					City or Tow	n, State)		ural Route Number,
	the Hosp in 24 hou the Funer upletely fil	ledical	(Check only 2 Medica	ing Physician: To the be it Examiner: On the basi and manner	is of examination	edge, death n and/or in	vestigation, in	my opinion,	, death occurre	ed at the time, o	date and	place, and due	e to the cause(s)
	P S S	Σ	29b. Signature and title of certific	Moran	10		29c. Lie	ense numb		2	29d. Date	a signed (Mont	n, Day, Year)
			30. Name and address of person	MD 8700	O Georgi	a Av	-	ilver	Sprin	g,MD 20	910		
	Sta Registr		31. Date filed (Month, Day, Year	2009 Seneta	istrar's Signature	par	10						

DHMH 17 Rev 1/2001

		Please	Type or Print in Blac				_	
		For State Registrar	State of Maryland / [Department of F Certificate of I		•	0000	0 01707
		Hegistrar Decedent's Name (First, Middle, L.)	ast)	Certificate of I	Journ	2. Date of De		3. Time of Death
Physicia /Medic		Wilbert	Dooley			June	Day 19 Yea 20	
Examin		4a. Facility Name (If not institution, g	1 1 0 11 1. 1	(1)	Location of Death		4c. County of De	ath
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year	Trmore	8. Date of Bir	th 9. E	sirthplace (State or Foreign
Director		253-44-4512	1 XX 2□ F 77	Yrs. Months Days	Hours Min.	8. Date of Bir (Month, Da March	9,1932 G	eorgia
and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
Maryl a-f sho	tor	Maryland Prince	George's 6014	Goodfellow I	Orive Suit	tland,	MD 20746	1 □Yes 2 VNo
ith the or 28%	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
eath w		6014 Goodfe	11ow Drive 12. Was Decedent Ever in U.S.		0746 Iionania Origina /Sna	ooifu Vos or No	USA	merican Indian,
after de or item	Funeral	11. Marital Status 1 □ Never Married 2√√√Married	Armed Forces?	13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)		nite, etc.
ours a	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Vietnam	1 □Yes 2√XXX	Specify:			Black
n 72 h	olete	15. Decedent's (Specify only highest g	rade completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	durina most of worki	ing	16b. Kind of Busines	•
filed within 72 hours after death with the Maryland Hygiene. Hygiene, with a trian "natural", or items 23a or 28a-f show ent, the Macrical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Food Service	e Supervi	sor	Gover	nment
be file ntal Hy d oth event,	Be	17. Father's Name (First, Middle, La.			18. Mother's Name		, Maiden Surname) Lawrence	
hould nd Mer marke matic	오	John 19a. Informant's Name/Relationship	Dooley	o. Mailing Address (Street				Zin Code)
nd 2 s alth ar 27 Is r trau		Mable Dooley		6014 Goodfe				20746
es 1 a of Hei		20a. Method of Disposition 11☑NgBurial 2 ☐ Cremation 3	20b. Place o cemete	of Disposition (Name of ery, crematory or other place	(e) June		9 ^{20c. Location - City}	or Town, State
t. Pagi tment tant: I		4 Donation 5 ☐ Other (Spec	ify) Maryla	and Veteran's	sCemetery	00,200	Chelten	ham,Maryland
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee MO1533	22. Name and Addres	TIE.	e Funer	al Home, I	nc. on, MD 20735
		23a. Part 1. Enter the disease, or co	mplications that caused the death. Do					Approximate Interval Between
Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line.	BLACKERE				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence	off:				
Examiner	er	Sequentially list conditions,	b. Enterocutane Due to (or as a consequence					
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
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w requires that the death certificate be ex been signed by the attending physician should be detached for use as the burial	Physician/Medica		d					
n certii ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of	delivery
e deat the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У		Month	Day Year
that thed the ed by detach		9 ☐ Unknown Part II. Other significant conditions	contributing to death but not resulting i	in the underlying cause give	en in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
quires in sign uld be	d by	Chronic Ren	al failure			1 🗆	Yes 2 1√10 3 □	Probably 4 Unknown
aw red as bee 2 shou	plete	Congestive He	art Failure			24a. Was		autopsy findings available to completion of cause of
The cate h	Completed	Chronic Africa	1 Fluffer			perfe	ormed2 death	?
sician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:	Oth	26. Place of Deati			
g Phy er this	n:To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/O	Time of 28c. Injur	4 LI Nursing Ho		idence 6 Other (S how injury occurred	pecity)
endin sath. or: Aft	atio	1 Natural 5 Pending investigati	on		Yes 2 □ No			
or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not determine		arm, street, factory, office		28f. Location (City or To	(Street and Number or wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier 1 Certifying	hysician: To the best of my knowledg	e, death occurred at the til	me, date and place,	and due to the	e cause(s) and manne	as stated.
the Ho in 24 th the Fu	Medical	(Check only 2 Medical Ex	aminer: On the basis of examination an and manner stated.	nd/or investigation, in my o	opinion, death occur	red at the time	, date and place, and o	ue to the cause(s)
Neith Corr	Σ	29b. Signature and toll of confifier	•	29c. Licens	e number		29d. Date signed (Mo	
	}	30 Name and address of parson wh	M.D. o completed cause of death (Item 23a)	/Type Print)	ロコノ		une	19,2009
BB1041V	A		1. Jessie , M.O.	(Type, Print) 22 Such Gi	reae St	Balt	inare, MD	21201
Sta	. 21	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1			<i>+</i>	•
Registr	ar	JUN 23	2009 Deneur B.	gares				

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatht and Mental Hygiene. Important: If Item 27 Is marked other than "naturat", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 20a. Method of Disposition 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be P 27. Manner of Death Certification: 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HOLLIN NITUTE D 51705 06-22-09 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR West minder 10 M. PANSURIYA Malcolm 31. Date filed (Month, Day, Year) 32. Registraric Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Ameno#14.PerFHPC06-26-09cr Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 4:05p 2009 Ferdinand Horatio June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Greenbelt 6801 Damsel Court 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 ☑ M 2 ☐ F June 1, Ĩ935 Guyana 214-02-3103 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinating the published at 1√2Yes 2 □ No Director Prince Georges Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Guyana 20770 6801 Damsel Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>გ</u> African 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Security Manager marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill if Health and Mental Hitem 27 is marked oth Be Keturah Noble Thomas Doris ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6801 Damsel Court Greenbelt M.D. 20770

ce of Disposition (Name of Date 20c. Location - City or Town, State Johnnie M. Doris/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 6-26-2009 Brentwood, MD

22. Name and Address of Facility Fort Lincoln Funeral Home Signature Funeral Service Licens 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): Examiner retes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 ☑No sate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 MNo certificate 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 5 Pending investigation 1 □Yes 2 □No 2 Accident s after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

State Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

(Check only one)

MD THOMAS

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Mercantile

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:55 a^M Everett Davis 2009 21, June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Willards 36871 Old Ocean City Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 X M 2 □ F Maryland 214-16-4950 94 07/28/1914 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Willards Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21874 36871 Old Ocean City Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2**X** No Specify <u>\$</u> white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Perdue Farms truck driver s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th other traumatic event, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Hall Arthur W. Davis ဂ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)
36885 Old Ocean City Rd., Willards, MD 21874 19a. Informant's Name/Relationship (Type. Print) Gloria Wainright/step-sister Department of Health a Important: If item 27 is any injury or other tra once. Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ment of P 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 6/25/09 Willards, MD New Hope Cemetery atura of Funeral Service Len 22. Name and Address of Facility Holloway Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21874 Approximate Interval Between Onset and Death A. Part 1. Enter the disease, or complications. If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car se on euch line. h mediate Cause (Final isease or condition resulting in death) ASCVO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (pisease or inju-that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) □Yes 2□No signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☑ No certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) Coastal 1 Yes VINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) Hospul Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Pruneral Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P D 63199

State Registr<u>ar</u> 30. Name and

DHMH 17 Rev 1/2001

EBN Shore DR, SA/15, MD 31804

doress of person who completed cause of death (Item 23a) (Type, Print)

Year)

Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DAVIS Time 15 C. WILLIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Marl boro 5819 Marlbor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. APRIL 18,1932 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Country) VIRGINIA Months 1⊠M 2□ F 77 Director 244-44-1069 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Extrainset must be prefitted at 14 Yes 2 □ No Director UPPER MARLBORO PRINCE GEORGES MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20747 #301 5819 MARLBORO PIKE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces XYes 2 No 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Yes. Give ò 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT DEPARTMENT OF AGRICULTURE 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVIS CATHERINE UNKNOWN UNKNOWN ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15759 POINTER RIDGE DRIVE BOWIE, MARYLAND 20716 19a. Informant's Name/Relationship (Type. Print) DESARIE JENIFER/ NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND 06-25-2009 RIVERDALE PARK 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Fundal Service License 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 3005 12th STREET N.E. WASHINGTON, DC 20017 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheroschero disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year In the past 12 months? Month Day 5 Other (specify) signed by the s ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 → nknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 → Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Medical

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a, Certifier

(Check only

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

09-04791 Rodney K. Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Time of Death 2. Date of Death Physician/ Month Day June 16, 2009 1458 hrs **Medical Examiner** Rodney K. Evans c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Oxon Hill 559 Wilson Bridge Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Days Hours Months Director 09/25/1962 577-90-5730 1 X M 2 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 'n 10b. County 1 X Yes 2 No s 23a or 28a-f show se notified at once MD Prince George's Oxon Hill Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 559 Wilson Bridge Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married 2 X No Yes Specify: Black Yes 2X No specify: Yes, Give Year Widowed 4 Divorced ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Business Machines 12 2 Technician 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phyllis J. Jackson Cornie L. Evans, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itimore, MD Phyllis J. Evans/Mother 310 Heyse Court, Ft. Washington, MD 20744 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/22/2009 Clinton, 4 Donation 5 Other Specify Resurrection 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licensee 6500 Allentown Rd., Camp Springs, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line M. dical Death a. Congestive Heart Failure Immediate Cause (Final disease **kaminer** or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed hysician/Medical UNPENDED AMENDED attending physician for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. No 3 Probably 4 ✔ Unknown \$ Yes 2 Chronic alcohol abuse Completed 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Other; Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 Pending Director: d in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 June 17, 2009 O.C.M.E. **OCME** 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 30, 2009 7:44 PM M Physician Mary Brewer Etchison /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Homewood at Crumland Farms Birthplace (State or Foreign Country) 8. Date of Birth
June 0, 1908 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🔽 101 207-26-0771 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at Frederick N☐Yes 2☐No Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number d 2 should be filed within 72 hours after death with hand Mental Hygiene.
7 is marked other than "natural", or Items 23a or retrammatic event, the Medical Examiner must be a traumatic event, the Medical Examiner must be a U.S.A. 21702 7407 Willow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify <u>م</u> 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida E. Mackley George W. Brewer, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Michael E. Schaden, Step Grandson 8105 Claiborne Court, Frederick, MD 21702 permit. Pages 1 an.
Department of Health
Important: If item 27,
any injury or other tra
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, MD Smithsburg Crematory July 2, 2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Littinsee ²²Keeney and Basford PA Funeral Home 21701 M00255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 201 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2≅No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation Natural in 24 hours are: the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Physician as: moun

29c. License number

.m.D. 300 West Ninth Steet, Frederick 21701

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** Vito Falcone June 21, 10:04 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, May 5, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** M 2DF Months Days Hours Italy May 79 577-56-6710 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural" or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Exeminer nust be notified at 1 ☐ Yes 2 No Director Prince George's Hyattsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7103 24th Place 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 █No Specify Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ornamental Ironwork Ornamental Ironworker ortant: If item 27 is marked othe Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta. Important: If Item 27 is marked c any Injury or other transmetts. Maria Antonia Policelli Antonio Falcone ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Falcone/Wife 7103 24th Place, Hyattsville, MD 20783 Date 26, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation a Mother (Specify) encombment Gate of Heaven Cemetery 2009 Silver Spring, Maryland 21. Signature of Furieral Sec Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Pan . Enter the discusse, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a o necque to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, MD 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. d #5 Per G894 8/10/09 IH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 2009 ALICE M. FORSYTHE /Medical Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examine 100 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** 222-34-6837 Days Min 1 □ M 2 🗓 F Months Hours Director 62 05/28/1947 VIRGINIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ortant: if item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at Director 1 Yes 2 No MD WORCESTER OCEAN CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 119 71ST STREET 21842 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify δ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Item Important or other traumatic event, Item Important Inc. Elementary/Secondary (0-12) College (1-4or 5+) 10 NEVER WORKED - DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES ADGER FORSYTHE, III ပ CATHERINE RODDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1890 LAMBS GAP RD MECHANICSBURG, PA 17055 CHERYL F. LENTZ/COUSIN altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GRACELAWN MEMORIAL PK | 06/27/2009 | NEW CASTLE, DE Af Funeral Service Licenses 22. Name and Address of Facility SPICER-MULLIKIN FUNERAL HOME 1000 N DUPONT PKY NEW CASTLE, DE 19720 23a. Part / Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expenses) Examiner be execute and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.O. the 9 Unknown ò s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 si autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours aner community to the Funeral Director: Aft 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DZS 06-22-2009 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO MO: 5382 CHINABERRY DR. SALISBURY, MD Z 1901

Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

			for State	State of M	/laryland / l				Mental Hy	giene2 () (9	21806
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X R O	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		c pregnancy			23d. Date Mont		ry Day Year
<u>.</u>	the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 □ Pregnant 9 □ Unknown	at time of death	5 🗆 Other	(specify)					,
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UIVISION	or Att fter de irect n by 1	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 28e. Place of Ir building, e	njury - At home, fa etc. <i>(Specify)</i>	ırm, street, fact	ory, office		28f. Location (S City or Tow	Street and Number n, State)	r or Rurai	l Route Number,
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	To the Hospital or Attending Physician: The I within 2 hours after death. To the Europeal Director: After this certificate ha capmpletely filled in by the funeral director, page	Medical	29a. Certifier Certifying (Check only 2 Medical E	g Physician: To the bes Examiner: On the basis and manner s	of examination a	e, death occurr nd/or investigat	on, in my opin	, uate and place nion, death occu	rred at the time,	date and place, ar	nd due to	the cause(s)
	Fo the	Me	29b. Signature and title of certifier				29c. License n	umber		29d. Date signed	(Month, I	Day, Year)
	VYIVE			•			Do	00581	110	6/10	1/0	3
	I'm Al		30. Name and address of person v	vho completed cause of	death (Item 23a)	(Type, Print)	No. of the last of	,		/1 /		
	Ast		GHusty W	Arris P.O	BOX	1733	SAU	as Bu	ry	wo	21	805
	Sta		31. Date filed (Month, Day, Year)	6	strar's Signature	presto	1		,			
	Registr	ar	JUN 23	ZUUS /CAPICH	was po.	17						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** John Ficik Jr. 2009 1, July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Memorial Hospital Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Mar. 23, 1932 9. Birthplace (State or Foreign Country) **PA** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F 77 217-28-0034 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hyglene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be multified at 1 ☐ Yes 2 No Director W Hampshire Green Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26722-9701 USA HC-86 Box 22 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Railroad Ty Plant 10 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Lawrence John Ficik Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any injury or other trau. Pages 1 and 2 sl ment of Health an WV 26722-9701 Betty J. Ficik HC-86 Box 22 Green Spring, (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/4/09 Green Spring, W 4 □ Donation 5 □ Other (Specify) Forrest Glen Cemetery: 22. Name and Address of Facility McKee Funeral Home 21. Signature of Funeral Service Licenses 115 E. Birch Lane Romney, WV 26757 23a. Part 1. Inter the disease, or complications that cause who death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner GRAVENS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 315 Wasa 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 Set on Dr. Robert Welik MD Cumberland, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Dir

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ay 4 **Physician** 2009 8:20A. M Irene Finkel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington 5. Social Security Number 8. Date of Birth Oct. 11, 1910 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year | If Under 24 Hrs 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🕏 F 98 144-10-5426 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at Oc. City, Town or Location
Silver Spring 10a State 10b. County 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2XNo Director 10g. Citizen of What Country? 10f. Zip Code 20906 3005 S. Liesure World Blvd, #826 Tumberty Apts. United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own bome 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sabott Rebecca Satinsky Abraham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3005 S. Liesure World Blvd.,#826 Turnberry Apt. Silver Spring, Md. 19a. Informant's Name/Relationship (Type. Print) Bernice Steinberg -niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 14 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o important: If any Injury or Mt. Lebanon Cemetery 6/28/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service license Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 nknown SCLEROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No MENT or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57284 JUN 24 2009 anan, 17P 1801 E. JEFFERSON ST MD 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Regionar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) GIVENS Month 1935 PM **Physician** JUN 2009 Edward DAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F 222-22-3988 1-23-1936 Delaware Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at X Yes 2 □ No Director DE Bethel Sussex 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 19931 USA Funeral 7773 Main Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/ Operator Excavation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Hint: If Item 27 is marked of Viola Allen Andrew C. Givens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health al Important: If Item 27 is any injury or other trau once. 7773 Main Street Bethel, De. 19931 (Wife) Charlotte Givens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Com. Cemetery 6-22-2009 Bethel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street 22. Name and Address of Facility
Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Final MEDWIND SITTED JAHMOORA WAS OHT RUPTURES **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical attending IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) signed by the att 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 2 🗌 No 1 Tes the Hospital or Attending Physician: " hin 24 hours after death.

the Funeral Director: After this certificat 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 □ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dlack 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 11:15 PM 2009 20, William E. Hutchinson Jr. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Village
| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 3, 1917 19121 North Pike Creek Place Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Massachusetts 92 Director 010-07-7315 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Montgomery Village MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 20886 19121 North Pike Creek Place United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot and 2 should be William E. Hutchinson Edith I Atwood ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a,
Important; If item 27 is
any injury or other trau Penelope Cochran/Daughter 20523 Golf Course Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia 22, Metropolitan Crematory June 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee East Deer Park Drive, MD 20877 DeVol Funeral Home, 10 IRACH H Caithersburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 1/2 Month Immediate Cause (Final **Physician** disease or condition resulting in death) Bladder Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, aftending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy for Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 X No 1 □ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🌠 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 🕅 Natural after death.

Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in t To the Hospital c 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific June 22, 2009 D43083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, #300, Rockville, MD 20850 George Sotos, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

JUN 23 2009

32. Registrar's Signature

Physici /Medic Examir

For State Registrar		State o	f Maryland		artment of h				giene?	09	21811
1. Decedent's Na	me (First, Mide	dle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
		Thelma N.	Hecht					June	•	2009	2:00 p ^M
4a. Facility Name	(If not instituti	on, give street and nu	mber)		4b. City, Town, o	r Location	of Death		4c. County		•
		Assisted Liv				evy Ch		O. Data of Dirett			omery
5. Social Security 055-01		6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. la 90	ist birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	 Date of Birth (Month, Day November 	, Year)	Gou.	place (State or Foreign ntry) New York
Usual Residence	of Decedent										10d. Inside City Limits
10a. State	10b. Count	У	10c. City	Town or Lo	cation						1 ☐ Yes 2 🛣 No
Maryland	100	ontgomery				Chevy	Chase		10a. Citizen of	NA/5-4 C	
10e. Street and N					10f. Zip Code		_		log. Citizen or		,
8100		cut Avenue,		140	Was Dasadant of L	2081		oifu Voo or No	14 Pa		can Indian,
Maryland 10e. Street and N 8100 11. Marital Status 1 □ Never Ma	s arried 2□ Ma	Armed Fo), 13,	Was Decedent of H If Yes, specify Cub	an, Mexic	an, Puerto I	Rican, etc.)	Bla	ck, White,	
3 Never Ma	ameu 2⊡ ivia I 4 □ Divorce	If Yes. G	ive		1 ☐ Yes 2 🔼 No	Specif	y:		Specif	fy:	White
	15. Decede	ent's Education			dent's Usual Occup		1.6.4.		16b. Kind of B	lusiness/Ir	ndustry
Flementary/Se	ecify only high econdary (0-12)	nest grade completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	during mo d)	ost of workir	ng			
3 🗷 Widowed		4			Teach					Educa	tion
17. Father's Nam		,				18. Mot	her's Name	(First, Middle,			
	Morri	s Nettler		1					laldenber		
19a. Informant's	Name/Relation	nship (Type, Print)		19b. Mailii	ng Address (Street	and Num	ber or Rura	l Route Numbe	er, City or Town	, State, Zi	p Code)
		n - Grandson			orth Wakef	ield S		- 1			
20a. Method of E		n 3 ☐ Removal from		ace of Dispo emetery, crei	osition (Name of matory or other pla	ce)	D	ate	20c. Location	- City or 1	own, State
4 Donatio	n 5 🗆 Other	(Specify)	Mt.		n Cemetery	i	06/21	/2009	Ade1ph	i, Mar	yland
21. Signature of	Funeral Service	Licensee	ull	H	2. Name and Addre lines-Rinal .1800 New H	di Fun	eral H	ome, Inc.	ver Sprin	g, Mai	yland 20904
23a. Part 1. Enter the disea or or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Interpretation on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of):											
		1									
Sequentially list if any, leading to cause. Enter Ur	conditions, immediate	D.	eripheral (or as a consequ			1 year					
if any, leading to cause. Enter Ur Cause (Disease that initiated eve resulting in deat	or injury	S .									
resulting in deat	h) Last	Due to	(or as a consequ	ence of):							
		d.									
IF FEMALE: 23b. Was deced in the past 1 □ Yes 9 □ Unkno Part II. Other sig	12 months? 2 X No	1 Live	itcome of pregna birth 2 Fetal gnant at time of d nown	death 3	☐ Ectopic pregnan ☐ Other (specify) _	су				ate of deli	very Day Year
Part II. Other sig		tions contributing to	leath but not resu	lting in the u	ınderlying cause gi	ven in Par	t I.	23e. Did to	obacco use cor	ntribute to	the cause of death?
								1 🗆 Y	∕es 2 x No	3□ Pro	bably 4 🗆 Unknow
										prior to c death?	copsy findings available ompletion of cause of 2 □No
25. Was case re examiner?	ferred to medic						ce of Death	(Check only o	ne)		
1 ☐ Yes 2			·		III OLI DOA			me 5 Resid			eify)
27. Manner of Do 1 Natural 2 Accident	5 Pend		e of Injury oth, Day, Year)	28b. Time o Injury	Wo	ry at rk?]Yes 2[28d. Describe h	now injury occu	rred	
3 ☐ Suicide 4 ☐ Homicid	6 ☐ Coul	d not be rmined 28e. Plac build	e of Injury - At ho ding, etc. (Specify	me, farm, st	reet, factory, office			28f. Location (\$ City or Tov	Street and Num vn, State)	ber or Ru	ral Route Number,
1 Yes 2 27. Manner of D. 1 Natural 2 Natural 3 Suicide 4 Homicid 29a. Certifier (Check only one)	1 🔼 Certify 2 ☐ Medic	ying Physician: To the al Examiner: On the and ma	e best of my kno basis of examina nner stated.	wledge, dea tion and/or in	th occurred at the nvestigation, in my	ime, date opinion, d	and place, leath occuri	and due to the red at the time,	cause(s) and r date and place	manner as e, and due	stated. to the cause(s)
29b. Signature a	and title of certif	fier Cl	_		29c. Licen	se numbe			29d. Date sign Ju n	ed (Month	
		on who completed cau				hevv (Thase -	Marvland			
31. Date filed (M		1220	Degiatror's Ciano	uro			,				
	IUN 23	2009 Den	ww p	. pa	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year <u>12:</u>20 P^M Mary Jane Harrington June 19 2009 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase 4701 Willard Ave. #330 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Hours Days **Funeral** Months 1 □ M 2√□ F Maryland 577-20-3222 10/30/1918 90 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 ☑ No Chevy Chase Funeral Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20815 4701 Willard Avenue Apt. 330 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ∐Yes 2 XNo fYes, Give 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 \$ 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Federal Reserve Elementary/Secondary (0-12) College (1-4or 5+) Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian M. Benson Earl G. Harrington မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bethesda, MD 20814 4824 Edgemore Lane Suzanne Snedegar / Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 06/25/2009 National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23d. Date of delivery IF FEMALE: yes, outcome of pregnancy Year 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No been signed by the should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 🗍 Unknown Completed by Arteriosclerotic Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s has 2 🗆 No 1□Yes 2√No 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

funeral director, After this or Attending after death.

I Director: After in by the fur filled in by To the Hospital of within 24 hours at To the Funeral Discompletely filled it

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James H. Brodsky MD 4701 Willard Ave. #224 Chevy Chase, MD 20815

6 ☐ Could not be determined

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 ☐ Homicide

(Check only one)

JUN 23

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

020297

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 19, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JÜNE 19, 2009 ANGIE MAE LORETZ HEMSLEY 12:05 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES CHARLES COUNTY NURSING & REHABILITATION CIR LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 😿 F NOVEMBER 16, 1924 NORTH CAROLINA 578-26-0700 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 27 is marked other then "natural", or items 23s or 28s-f ebor traumstic event, the Madical Express or must be multified at 1 Yes 2 No MARYLAND CHARLES WALDORF Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 11649 CYGNET DRIVE UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Maryland 21215-0036 Specify. Specify: BLACK 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7TH GRADE BUILDING SERVICE WORKER **EDUCATION** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CHARLIE LORETZ ANGIE ANTHONY LORETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 BRENDA THOMAS / DAUGHTER 12950 WEST HATTON ROAD, MT. VICTORIA, MARYLAND 20661 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CEMETERY JUNE 26, 2009 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify) 21. Surfature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LADIA C. THORNION JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine burial-transit certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions/pontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital : After this certifical funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a To the Funeral L 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Mopth, Day, Year, 29b. Signature and title of certifier 00 Daid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Line Ctr. Ste. eatherwood 2r Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Ambrose Leo Hess June 22, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Shepherd's Glen Assisted Living Tanevtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 18, 6. Sex 7. Age (In yrs. last birthday) **Funeral** .^{Year)}915 Days Hours 1 M 2 F 93 219-36-0809 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machinal Emphasisment. 10c. City, Town or Location Taneytown Funeral Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 1403 Trevanion Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Be Completed by Specify. Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Dairy Farmer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgie Stultz Richard N. Hess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 1808 Otterdale Mill Road, Taneytown, MD 21787 Lavaughn P. Dickinson, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/24/2009 Taneytown, MD Grace UCC Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. ALZHEIMERS Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of)

Due to (or as a consequence of):

 Hospital or Attending Physician: The law requires that the death certificate be executed
 A hours after death.
 Funeral Director: After this certificate has has a sinned by the the certificate has has been sinned by the certificate by the certificate has been sinned by the certificate by the certificate has been sinned by the certificate by the certificate has been sinned by the certificate by the ce To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed

Division of Vital Records, P.O. Box 68760,

	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	_	23d. Date of delivery Month Day Year
Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unkno
		24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death?

26. Place of Death (Check only one)

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier 29c. License number 0014317

29d. Date signed (Month, Day, Year) June 22, 2009

OPEKINGS DRIVE TANEYTOWA, NO 2178

3. Time of Death

5:00 a M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Maryland

white

USA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM HICUM

31. Date filed (Month, Day, Year)

25. Was case referred to medical

examiner'

32. Registrar's Signature

Registrar

State

WJL 10

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** Day Year CM :15 20 /Medical 2009 4a. Facility Name (If not institution, give street and number) County of Death **Examiner** If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In ws. last birthday) **Funeral** Year) Months Days Min. 1 M 2 □ F Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Exeminar must be notified at 1XYes 2 □ No Director Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 Lasalle Road 20782 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: Black 1 □Yes 2 XNo Specify 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ins. 11. Elementary/Secondary (0-12) College (1-4or 5+) 6th Warehouse Laborer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Johnson Mildred Pilton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy S. Johnson, Jr./ Grandson 4712 Sharon Road Temple Hills, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 30, 2009 Cheltenham, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC on 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCIENOTIC Andiovascular 4-cons /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Gangrene 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed DEFELT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Blindness 1 ☐ Yes 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 5 2009

completed cause of death (Item 23a), (Type, Print)

42036

D01852

IEENSBURY Rd HYGHTSV: 110 MD 20781

29d. Date signed (Month, Day, Year)

JUNE 20 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear JOY 1300 22 L/AUN 2009 4c. County of D 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death Silverspring Hospita Monta omer C8055 Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 693-10-8846 1 □ M 2 😿 F Months Days 35 Bungladesh Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Bangladest 22204 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Asian Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Drog 17. Father's Name (First, Middle, Last KHAN TAUL 19a. Informant's Name/Relationship (Type. Print) CHOWDHU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SK MIR MD AL MAMUN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DHAKA DHAKA BANGLADESH 22. Name and Address of Facility ADEN MUS. (im Funeral for. 21. Signature of Funeral Service Licensee Dhillip! 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dung, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ancer Due to (or as a consequence of): minated Overian Cancer Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseque Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 [9 Unknown 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Examiner requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician as the nse for signed by the a d be detached f cate has been si page 2 should b certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Physician

Examiner

/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

≥

Completed

Be

ပ

? is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Evani inc must be notified at

the Maryland

death with

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

29b. Signature and title of certifier

Physician/Medical ð Be Completed Certification: To

				1 □ Yes 2 □	No 3 Probably 4 Unknown
			× (- 1 = 1	24a. Was an autopsy performed? 1 □ Yes 2 ▼No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	Physician: To the best of my kraminer: On the basis of examinand manner stated.				

7

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 FOREST GLEN RD. SILVER SPRING MD20910 MD.

68150

29c. License number

29d. Date signed (Month, Day, Year)

2009

State Registrar 31. Date filed (Month, Day, Year JUN 2 4 2009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		State of Ma	ıryland		artment of rtificate of			-	gien Reg. N	000	0	010	
			Negistrar Decedent's Name ((First, Middle, Las	t) Brooklin	В. Ј					2. Date of De	ath		-	3. Time of De	eath
	Physici /Medic		- Brookly:	n B.	Jackse	n					June 1	7,	2009 Yea	ır	7:45 a	a M
1	Examin	er	4a. Facility Name (If r					4b. City, Town,				4	c. County of De			
art d	Funeral		Holy Cros 5. Social Security Nur			(In yrs. la	st birthday)	Silver If Under 1 Year			8. Date of Bir (Month, Da	th	Montgo 9. E	Birthola	ace (State or I	Foreign
Н	Funeral Director		578-32-59	1		5	Yrs.	Months Days	Hour	s Min.	Dec. 1	0, Year	1923	Counti SC	<i>y)</i>	
	and w		Usual Residence of D 10a. State	Decedent 10b. County		10c City	Town or Lo	cation						10	d. Inside City	Limits
	Maryle f sho	or	DC	TOD. COUNTY			shingt								1 ⊠Yes 2	
	r 28a	Director	10e. Street and Numb	per		Wat	J1111116 C	10f. Zip Code				10g. C	Citizen of What	Countr	y?	
	th with		1221 T.	St. NW				20009)			U	SA			
21215-0036	I within 72 hours after death with the Maryland liene. I then "natural", or items 23a or 28e-f show the Medical Exeminar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🖾 No			ecify Yes or No Rican, etc.))-	14. Race - Al Black, Wi Specify:		c.	
2-0	72 hou natura licel F	eted	(Specifi	5. Decedent's Ed y only highest gra	ucation	Ţ	16a. Dece	dent's Usual Occu	pation	aget of work	na	16b.	Kind of Busine			
121	C * 3	Completed	Elementary/Second		College (1-4or 5-	+)	`life. I	DO NOT use retire	ed)	iost of work	ng		IJPO			
d 2	Hyg the int,		17. Father's Name (Fi	irst. Middle. Last)	2 yrs.		Socia	ıl Worker	Т	other's Name	(First, Middle	. Maide				
lan	d dal	To Be	Peter For						Bra	zie J	ackson					
lary	- G & =		19a. Informant's Nam	ne/Relationship (7	ype. Print)		19b. Mailir	ng Address (Stree	t and Nui	mber or Run	al Route Numb	er, City	or Town, State	e, Zip (Code)	
€, <		9	Patricia 1		Daughter	Logi Bi		Decatur lbridge,				00-	Location - City	T	- 04-4-	
Baltimore, Maryland	S = 0			Cremation 3	Removal from State			sition (Name of natory or other pla			Date				n, State	
altin	# E E E .		4 ☐ Donation 5	i □Other <i>(Specify</i> eral Service Lice n		Kes		tion Cem rysnaldrog			-		inton,	MD.		
ä	Depa Impo any Ir		Dere	1 %	llower	-		308 Suit					MD. 207	46		
1	Physician	50.5	shock, or heart Immediate Cause (Fi disease or condition	failure. List only	lications that caused one cause on each lin Urosepsi	e.	Do not ent	er the mode of dy	ing, such	as cardiac	or respiratory a	arrest,			Approximate Interval Betwee Onset and De WKS	en ath
	/Medical Examiner		resulting in death)		Due to (or as a									,	1-	
		er	Sequentially list cond if any, leading to imm	litions, ediate	b. Renal Fa							-		1	wk	
	cuted nd ransit	Examiner	Sequentially list cond if any, leading to immodus. Enter Underly Cause (Disease or in that initiated events	ing jury	c. Pulmonar	y Ede	ema							2	wks	
30,	ificate be executed g physician and as the burial-transit	Ex	resulting in death) La	st	Due to (or as a	conseque	ence of):			•						
68760,	icate t physic the b	edical			d									+		
O. Box	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 14 9 □ Unknown	onths?	23c. If yes, outcome of the second of the s	2 🗌 Fetal	death 3	☐ Ectopic pregnan ☐ Other (specify)	су				23d. Date of Month		ry Day Ye	∍ar
S, P.	law requires that the das been signed by the	by P	Part II. Other signific		9		0	, , ,		rt I.	23e. Did		use contribute			
ord	require een si nould b		Alzheimer								10	Yes	2 2 40 3	Proba	ably 4 □ Un	ıknown
Division of Vital Records,	The lar ate has bage 2	Completed			Thrive, Ch	ronio	e Atri	lal Fibri	lllat	ion	24a. Was auto perfo 1 □ Yes		prior death	to com	sy findings av apletion of cau	/ailable use of
ΖÏ	Physician; this certifical director, p	o Be	25. Was case referred examiner? 1 ☐ Yes 2	. +	Hospital:	nt 2 🗆 E	EP/Outpation	nt 3 DOA Ot	hor:		n (Check only o		6 ☐ Other (S	an oife)	
J of	ig Phy ter this neral d	n: To	27. Manner of Death		28a. Date of Injur (Month, Day	y 2	28b. Time of Injury				28d. Describe			респу	!	
sior	Attending or death. ector: After by the fune	catio	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not be		, //	1111011		Yes 2	□No						
.i×i	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Inju building, etc			eet, factory, office			28f. Location (City or To	Street a wn, Sta	and Number or ite)	Rural	Route Number	er,
_	Hospital		29a. Certifier 1	Certifying Ph	ysician: To the best o	of my know	ledge, deat	h occurred at the	time, date	e and place,	and due to the	cause	(s) and manne	r as st	ated.	
	he Ho in 24 h he Fu ipletely	Medical	(Check only 2 one)	☐ Medical Exam	iner: On the basis of and manner sta	examinati	on and/or in	vestigation, in my	opinion,	death occur	red at the time,	, date a	ind place, and	due to	the cause(s)	
+	To the within 2 To the comple	Σ	29b. Signature and tit	V	0			29c. Licen	se numb	er	_		Date signed (Mo			
	2				varich, R				006	5485			06/18	10	009	
	3		30. Name and addres Barbara 31. Date filed (Month,	Supanich	, RSM, MD	150	00 For	est Gler	Dr.	Si1	ver Spr	ing	, MD.			
	Sta Registr		31	N 2 4 200	9 2. Registra	, 1	40	Ker								

			_ For	State of Mary	/land / De _l	partment of F	lealth and N		•	
			1 - State Registrar		C	ertificate of	Death		g. No. 2	2 8 8
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
The	/Media	cal	Robert John Kwese					June 20		9:12 A M
	Examin	ier	4a. Facility Name (If not institution, give		t o 1	Ab. City, Town, o	Location of Death		4c. County of Dea	
r.M	Funeral		Shady Grove Advention 5. Social Security Number 6. Se		Lal n yrs. last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		004-34-3370	JM 2□F 72		Months Days	Hours Min.	02/24/19	937 Ma	ine.
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	ō	Maryland Montgome			ery Villa	70			1 TyYes 2 □ No
	r 28a	irec	10e. Street and Number	. L y	Honegon	10f. Zip Code	50	10	g. Citizen of What Co	ountry?
	h with	Funeral Director	10200 Battleridge	Place		20	0886		United St	ates
	deat	ıner		12. Was Decedent Ever Armed Forces?	r in U.S. 1:	B. Was Decedent of H		pecify Yes or No-	14. Race - Ame Black, Whit	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "distal Erain from" unto notified at	by Fc	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1★ Yes 2 No If Yes, Give Year or Dates:	1955 - 1957	1 □ Yes 2X No	Specify:		Specify: Wh	
21215-0036	thour	ted	15. Decedent's Edu	cation	16a. De	cedent's Usual Occup	ation	1	6b. Kind of Business	
215	hin 72 9. an "ne Madik	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Gi life	ve kind of work done DO NOT use retired	during most of work ii)	ting		
CA	should be filed withir nd Mental Hygiene. marked other than matic event, h. N.	Completed	Ziomonary/Secondary (C 12)	5+	Tal	k Show Ho			Radio	
nd	be filed tal Hygi d other event,	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, M	*	
<u>X</u>	2 should be fi h and Mental f is marked of raumatic eve	မ	John Paul Kwesell					anasheusl		
Maryland	12 sh th and 7 is m traum		19a. Informant's Name/Relationship (T)						City or Town, State,	
<u>မ</u> ်	1 and 2 Health Iem 27 i		Linda L. Kwesell (20a. Method of Disposition					Date 2	omery Vill	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		position (Name of rematory or other place	, 0 0	e 26	Í	
Ħ	nit. F artme ortan injur e.		21. Signature of Funeral Service Licente			itan Crema 22. Name and Addre		Vol Fune:		, Virginia
Ã	Deparent Impo		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	М00689			DC			MD. 20877
			23a. Party Ente the disease, or complete the disease, disease							Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	Respirate						Onset and Death Hours
	/Medical		resulting in death)	Due to (or as a co		ule				Hours
	Examiner	<u>.</u>	Sequentially list conditions,	b. Cor Pulmo						Weeks
6	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Pulmonary		ension				Years
0	e exec an an rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a co						
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		Obstruct:	ive Slee	p Apnea				Years
Box 6	certifi nding ise as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy				23d. Date of de	divery
ă	death e atter	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		B ☐ Ectopic pregnanc D ☐ Other (specify) _	у		Month	Day Year
P.0	that the denetation of the detached	hys	9 Unknown	9 Unknown						
S,	res tha igned be det		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying cause giv	en in Part I.			o the cause of death?
oro	w requires been sign should be	ted	Obesity					1 ∐ Ye	s 2 No 3 F	robably 4- Unknown
Records,	e law has t	Completed by	Renal Failure					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
<u></u>	ician: The I certificate ha ector, page		Diabetes 25. Was case referred to medical					1 □ Yes 2	□ 1 □ Ye	s 2 No
Vital		o Be	examiner?	Hospital:	2 ER/Outpat	innt 3 DOA Oth	or:	th (Check only one		
	ding Phys h. After this funeral dir	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injur		28d. Describe how	nce 6 Other (Spewinjury occurred	эспу)
0	Attending r death. ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye	ear) Injur		Yes 2 □No			
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, Specify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	ural Route Number,
	Hospital of the state of the st	0	29a. Certifier 1 XCertifying Phy	sician: To the best of m	ny knowledge de	ath pagurad at the ti	ma date and place	and due to the oc	upo(o) and manner	ac stated
	e Hos 124 hc e Fun letely	Medical		iner: On the basis of ex and manner stated	amination and/or	investigation, in my	ppinion, death occur	rred at the time, da	ite and place, and du	e to the cause(s)
	To the within 2 To the complet	Re	29b. Signature and title of certifier	72/1		29c. Licens	e number	29	ld. Date signed (Mon	th, Day, Year)
	15+1		A DOUR A	BALL W	5	D53	317		June 22, 2	2009
			30. Name and address of person who co		, , , , ,	e, Print)				
			Joseph Ball M.D.			ad #213 G	aithersbu	rg, MD.	20877	
	Sta Registr		JUN 23 200	32 Registrar's	Signature	arked				

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Old Line

225

MD

	1	State of Maryland / Depa	rtment of Health and M	_	0.0	00 01000
		Registrar 1. Decedent's Name (First, Middle, Last)	incate of Death	2. Date of De	Reg. No.	3. Time of Death
Physician		Michele Sara Liebes		Month		7:15 p M
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
Examine		4920 Sentinel Drive, #206	Bethesda		Montgo	omery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bird (Month, Da	th Year)	Birthplace (State or Foreign Country)
Director		566-90-0131 1□ M 2△F 57 Yrs.	World's Days 110d/3 Will.		0, 1951	Germany
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
Maryl f sho	5	Maryland Montgomery Bet	hesda			1 □Yes 2 🔀 No
r 28a	၌ -	10e. Street and Number	10f. Zip Code		10g. Citizen of Wh	nat Country?
h with	ב ב	4920 Sentinel Drive, #206	20816		USA	
be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, its its deal Evar treat coust to motified at		11. Marital Status 12. Was Decedent Ever in U.S. 13. Warned Forces?	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	- American Indian, , White, etc.
s after	בׄ ב	1 Never Married 2 Married 1 Yes 2X No	□Yes 2√E No Specify:	,		White
hours hours	2	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. Decede	ent's Usual Occupation		16b. Kind of Bus	iness/Industry
in 72 n "na n "na	nataidilloo	(Specify only highest grade completed) (Give k	ind of work done during most of worki O NOT use retired)	ng	100. 11.11.0 0. 200	
d with giene greene	5	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Wr	iter		Federa	l Government
d othe		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,	Maiden Surname)
yid build b Ment arkec atic e	5 .	Bernard H. Liebes	Georgette	P. N	inet	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantum right to notified at once.		19a. Informant's Name/Relationship (Type. Print) Rachele Arielle Oliver/Daughter 4920	Address (Street and Number or Rura Sentinel Drive. ‡	al Route Numb ‡206. B	er, City or Town, S ethesda.	State, Zip Code) MD 20816
1 and 1 and 1 tem 2 tem 2 ther	+	20a. Method of Disposition 20b. Place of Dispos		Date		Dity or Town, State
ages ent of nt: If it		11 Buriai 24 Uremation 31 Removal from State 1	June	22,	Maranda	ria, Virginia
mit. F Sortar Sortar Pinju	ŀ	· Detriction of Detrict (openity)	Name and Address of Eacility Tancis J. Collins			
Depa Depa Impo any ir		Joseph P. Lotz	00 University Blv	d. W.,	Silver S	Spring, MD 2090
	П	23a. Parl 1. Enjer the disease, or complications that caused the death. Do not enter shack, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Physician		Immedia e Cause (Final disease or condition Primary Peritonea	1 Cancer			Onset and Death 2 years
/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				4,0
executed executed in and ial-transit		Cause (Disease or injury				
exection and and rial-tree	LYG	that initiated events ' c				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Modical Contribution: To Be Completed by Bhysician Madical Contribution in the physician and physic	2	d				
entificating phases the		IF FEMALE:				
t the death certific by the attending p ached for use as	2	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date Mon	of delivery th Day Year
the de	2	1 ☐ Yes 2 ■No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			
w requires that the death cer been signed by the attendir should be detached for use	_	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	23e. Did 1	obacco use contri	bute to the cause of death?
equires t				1 🗆	Yes 2 X No	3 ☐ Probably 4 ☐ Unknown
: The law requir	1			24a. Was	an 24b. W	ere autopsy findings available
The Is					rmed? de	rior to completion of cause of eath? □Yes 2 □No
ician:		25. Was case referred to medical examiner?	26. Place of Deatl			
hysic this ce		1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5. 【X Resi	dence 6 □Othe	r (Specify)
ing Pt	<u>:</u>	27. Manner of Death 1 🗗 Natural 5 □ Pending 28a. Date of Injury 28b. Time of Injury 27. Injury 28b. Time of Injury 2b. Time of Injury 2b. Time of Injury 2b. Time of Injury 2b. Time of	Work?	28d. Describe	how injury occurre	d
ttend death death ttor: , the f	2	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location /	Ctract and Alumba	war Dural Bouta Number
tal or Attending F rs after death. al Director: After led in by the funer?	5	4 ☐ Homicide	et, factory, office	City or To	wn, State)	r or Rural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the	cause(s) and mai	nner as stated.
the Hospi nin 24 hou the Funer npletely fil	<u>.</u>	(Check only 2 Medical Examiner: On the basis of examination and/or inv one) and marines stated.	estigation, in my opinion, death occur	red at the time,	date and place, a	nd due to the cause(s)
To the within Common Co		29b. Signature and title of certified	29c. License number		_	(Month, Day, Year)
10			D65214		June 22	2,2009
		30. Name and address of person who completed cases death (Item 23a) (Type, F Lisa McGrail, MD 5454 Wisconsin	r _{int)} Avenue, #1300, Ch	evy Cha	ase, MD 2	20815
State Registrar		JUN 23 2009 Centra S. Again	W.			

DHMH 17 Rev 1/2001

			_ FOI	partment of Health and Nertificate of Death		ene g. No. 2000 21021
	Physicia		1. Decedent's Name (First, Middle, Last) Mary A. Lawrence		2. Date of Death June 21	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, give street and number) Montgomery General Hospital	4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery
H	Funeral Director		5. Social Security Number 5. Social Security Number 5. Social Security Number 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 M F R R R R R R R R R R R R R R R R R R	Months Days Hours Min.	8. Date of Birth (Month, Day, May 19,	Year) 9. Birthplace (State or Foreign Country) Pennsylvania
	d 2 should be filed within 72 hours after death with the Maryland than Montal Hygiene. The marked other than "natural" or items 23a or 28a-f show traumatic event, the Mardical Examination at the montal part of the marked of th	Funeral Director	10e. Street and Number 11715 Devilwood Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Location Omac 10f. Zip Code 20854 3. Was Decedent of Hispanic Origin? (Spiryes, specify Cuban, Mexican, Puerto		10d. Inside City Limits 1 □ Yes 2 ☒ No Dg. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036	filed within 72 hours after Hygiene. ther than "natural", or i ent, the Modeal Exemi	Completed by	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	1 ☐ Yes 2 ☐ No Specify: seedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired) rogram Analyst 18. Mother's Nam	king	Specify: White 16b. Kind of Business/Industry Federal Government faiden Surname)
arylan	should be and Mental s marked of umatic ev	To Be	Andrew Archangel 19a. Informant's Name/Relationship (Type. Print) 19b. M.	Elvira Le ailing Address (Street and Number or Ru		City or Town, State, Zip Code)
ore, M	ges 1 and 2 t of Health If item 27 I or other tra		20a. Method of Disposition 20b. Place of Dis	rematory or other place)		Spring, MD 20906 20c. Location - City or Town, State
Baltim	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		4 □ Donation 5 □ Other (\$pecify) 21. Signature of Fun Fal Servi X Lic_lisee	22. Name and Address of Facility Francis J. Collins	Funeral	Alexandria, Virginia Home Inc. lver Spring, MD 20901
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Ovariable to (or as a consequence of): Right Foot Gangrable to the consequence of the course of the cours	enter the mode of dying, such as cardiac	or respiratory arre	Approximate Interval Between Onset and Death
O. Box 6	the death certific the attending points for use as	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.		pacco use contribute to the cause of death?
<u> </u>	The ate h page	Completed			24a. Was ar autops perforn 1 □ Yes 2	y prior to completion of cause of death? 1 Yes 2 No
. VII	Si Si	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ♣No Hospital: 1 ▼ Inpatient 2 □ ER/Outpa	Other:	th <i>(Check only one</i> ome 5 ☐ Reside	e) ence 6 □Other (<i>Specify</i>)
Division of	ding h. After fune	ertification:	27. Manner of Death Matural 5 Pending 2 Accident 1 1 2 3 3 3 3 4 5 2 3 3 5 5 5 5 3 Suicide 6 Could not be 380 1 3 3 3 5 5 5 5 5 5 5	ry Work? M 1 □ Yes 2 □ No		w injury occurred
DIV	ipital or Atten ours after deat leral Director; filled in by the	Certifi	3 ☐ Suicide 6 ☐ Could flot be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	To the Hosp within 24 hou To the Funer completely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/c and manner stated.			
	withi Comp	M	29b. Signature and title of certifier	29c. License number D63383		9d. Date signed (Month, Day, Year) June 22, 2009
			30. Name and address of person who completed cause of death (Item 23a) (Tyl Rakesh Malik, MD 900 Olney-Sandy	pe, Print) Spring Road, Sandy	Spring,	MD 20860
	Sta Registr	_	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Sarkes		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 June 18, 7:20 a M Carole Linda Lescalleet 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Hospice Dove House Carroll Westminster 7. Age (In yrs. last birthday)
72 Yrs. 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 28, Social Security Number Days Hours Months 1937 Maryland 214-34-4137 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Westminster 1 ☐ Yes 2X No Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 650 Jasontown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No white Specify: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry
Carroll County 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Public Schools Elementary/Secondary (0-12) Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Selders Norman O. Eckard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 650 Jasontown Road, Westminster, MD 21158 Kellie S. Stonesifer, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Mary's Cemetery 6/22/2009 Silver Run, MD 22. Name and Address of Facility Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that cause shock or heart failure. List only one can see the each the death. Do not en in the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liecae of Figur, that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1-1No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

items ?

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'natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If all Me

death with the

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

and physician a s the burialas nse 호 the signed by t I be detach has After this certificate he funeral director, page

Examiner Physician/Medical ģ Completed

The law requires that the death certificate be executed Hospital or Attending Physician:

WJZ 10

25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) 29d. Date signed (Month. Dav. Year) 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster Streit South Flauro Kruter State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

parks

Registrar

State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	State of Ma	i yiana 7	•	tificate of L			Reg. No.	2000	21921
Physicia		Decedent's Name (First, Middle, Last VINCENT		UZZETT	A JI	R		2. Date of De Month	Day	Year 2009	3. Time of Deathr
/Medic Examin		4a. Facility Name (If not institution, give		0/4/1911	A 0.		Location of Death	I. O.UIIC		County of Dea	
."	•	Frederick Memor:	ial Hospit	al		Frederi	lck			Frederi	ck
Funeral Director		Social Security Number 6. Security Number		(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D April	rth av, <i>Year)</i> 3, 19	42 New	thplace (State or Foreign ountry) York
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation					10d. Inside City Limits
Mary -fsh	ţō	New York Saratoga		Ba11:	ston	Spa					1 □ Yes 2 XXNo
r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	ountry?
3a o	<u>a</u>	16 Deerfield Place	<u> </u>			12020)		Un	ited St	ates
ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	/as Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N	0-	14. Race - Ame	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Examination at Local Local Examination and Injury or other traumatic event, I'm Modical Examination and Once.	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	1959- 1962	• ,	Yes, specily Cuba	Specify:	rican, etc.)		Specify: W	hite
"natur	Completed	15. Decedent's Edi (Specify only highest grad	ication le com <i>pleted)</i>	16	(Give k	ent's Usual Occup kind of work done of ONOT use retired	during most of work	ing	16b. Ki	ind of Business	/Industry
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uld be f Mental I rked of	To E	Vincent LaBuzzetta	1				Mary T.	Caparo)		
and I s ma		19a. Informant's Name/Relationship (7	ype. Print)			-	and Number or Ru				
es 1 and 2: of Health a f Item 27 is		Kareen LaBuzzetta	/ Wife				Dr., Wal				
permit. Pages 1 ar Department of Hea Important: If Item 3 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Arer (Specify				sition (Name of eatory or other place Cremato:		22 , 2009		ocation - City or lerick,	Maryland
permit, I Departm Importal any Inju		21. Signature of Fur and Service Lio.	7	1000	Re22	Name and Address thaven	s of Facility Funeral S tin Mtn.	ervices	s, Sk	kot Coo	ly P.A.
Physician	2. 1	23a. Part1. Enter the disease, or compshook, or heart failure. List only of Immediate Cause (Final disease or condition		the death. Do	o not ente					ick, m	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a		6.	upra 1	velear	pal	Y		MONTHS
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tificate be ex g physician as the burial.	edical		d								
The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year
s that the	by Ph	Part II. Other significant conditions co	ontributing to death bu	t not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
v require been sig should b	ted b							1	Yes 2	□ No 3□ F	Probably 4 X Unknown
	Completed					· · · · · · · · · · · · · · · · · · ·		24a. Wa aut per 1 □ Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?	Hospital: 🔏			Oth	26. Place of Dea				
chys this al dir	ပ္	1 Yes 2 No	1 Inpatie	1		1 3 DOA	4 L Nursing H				ecify)
Attending Ir death. sctor: After by the funer	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	(Year)	o. Time of Injury	28c. Injur Wor M 1 □	yan k? Yes 2 □ No	28d. Describe	a now mja	ry occurred	
	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, stre	eet, factory, office		28f. Location City or To	(Street al own, State	nd Number or F e)	Rural Route Number,
te Hospital or 24 hours afte te Funeral Dir	Medical (29a. Certifier (Check only one)	ysician: To the best of finer: On the basis of and manner sta	examination	ige, death and/or in	occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time	ne cause(s e, date an	s) and manner d place, and du	as stated. ue to the cause(s)
	Me	29b. Signature and title of certifier	Y			29c. Licens				ate signed (Mor	
5+1		30. Name and address of person who of RAYEEN BUL	ompleted cause of de	eath (Item 23a	a) (Type, I	Print)	Forhi	0100	40	Lizn)-
Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		barel	(20 1)	, rece			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 19, 8:00 JUNE 2009 Α SANDRA THERESA LEGRAND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 1300 Waterford Drive District Heights If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04-05-1941 9. Birthplace (State or Foreign Wash., D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 68 577-56-5583 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location show the Medical Exercited hust be notified at 1 √ Yes 2 No Director District Heights Maryland Prince George's 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 20747 USA 'natural", or items 23a 1300 Waterford Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24 ☐ No þ Specify. Specify: Black 3x Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) US Postal Service Mailhandler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Hawkins William Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin J. Legrand/son 1300 Waterford Dr. District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 06 - 27 - 09Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01374 Mary Hedgman Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASVD probable disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): DM physician and s the burial-trans Due to (or as a consequence of): Physician/Medical HTN use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 TNNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1X XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760. Division of Vital Records. Director; After that in by the funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director; After

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)
5100 Auth Way Suitland, Maryland 31. Date filed (Month, Day, JUN 2 5 2009

29a. Certifier

29b. Signature an

Medical

and manner stated.

DHMH 17 Rev 1/2001

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

20746

			1 - For State Registrar	State of Ma	aryland				ealth and I Death		giene Reg. No.		
	Physici /Medic		Decedent's Name (First, Middle, La Ronald	s <i>t)</i> B.	Lo	hr				2. Date of De Month Jun 3		Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, giv Allegany County		me		Cί	ımbe			4c. Count	y of Death	
	Funeral Director		177-14-0102		9 (In yrs. Ia:	st birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sep 2	, 1921	9. Birth	place (State or Forei
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County Miner	al	10c. City,	Town or Lo							10d. Inside City Limi
	with the h	Funeral Director	10e. Street and Number Rt. 4 Box 16				10f. Zi	p Code	26753		10g. Citizen of	What Cou JSA	untry?
920	De liled within 72 hours after death with the Maryland ital Hygiene. At the Hygiene do other than "naturel", or items 23a or 28a-1 show event, ire Madical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Dece f Yes, spo 1 ☐ Yes		ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	- 14. Ra Bla Speci	ick, White	ican Indian, , etc. Nite
121	- 3	Completed by	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)		i+)	16a. Deced (Give life. L	kind of w DO NOT I	ork done o use retired	during most of wo f)	rking	16b. Kind of E		ndustry
land 2	hould be filed withing Mental Hygiene. marked other than matic event, its M	To Be Co	17. Father's Name (First, Middle, Last James Lohr)			<u> </u>			ne (First, Middle rine Lol	Maiden Suma		,
Mar	nd 2 s lith ar 27 ls 1 rau	F	19a. Informant's Name/Relationship (_{Туре, Print)} wife		19b. Mailin Rt. 4	g Addres Box	s (Street 16	and Number or Ru	ral Route Numb Ridg	er, City or Town Jeley	, State, Zi	ip Code) VV 26753
e e	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 Burial 2 Compation 3 4 Donation 5 Other (Special		cer	ace of Dispo metery, cren t Ashby	natory or	other place	ee)	7/8/2009	20c. Location	•	
Balti	permit. Pages Department of Importent: If It any injury or o		21. Signature of Juneral Pervio Lio-	588		22			ili Funeral ginia Aven			D 2150	02
	The private transit to build the private transit to build	edical Examiner	23a. Part / Enter the disease, or so shock, or hear failure. List vily immediate Cause / Final disease or condition resulting in death. Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1/	a conseque	VAS Cence of):			Aec 1				Interval Between Onset and Death
O. Box 68	the death certification the attending hed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal c	death 3	Ectopic (pregnancy pecify)				ate of deli	very Day Year
ds, P.	ures that the signed by Id be detac	ρχ	Part II. Other significant conditions	contributing to death b	ut not resul	lting in the u	nderlying	cause giv	en in Part I.		tobacco use cor Yes 2 No		the cause of death?
		Completed								24a. Was auto perfo 1 \(\text{Yes}		Were autorior to codeath?	topsy findings availate on pletion of cause of 2 No
Vital	Physicien: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	unt 2∏E	ER/Outpatien	nt 3 🗆 🗅	Oth Oth	00	ath <i>(Check only i</i> Home 5 ☐ Resi		her (Sner	rifu)
	aing Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	17	28b. Time of Injury		28c. Injur Wor			how injury occu		
Division	in Qifte	Certification:	3 Suicide 6 Could not be determined		ury - At hon c. <i>(Specily)</i>	ne, farm, str	eet, facto	ry, office			Street and Nurr wn, State)	ber or Ru	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Directional Direction of the Completely filled in the Completely f	Medical (nysician: To the best of miner: On the basis of and manner sta	examination								
	withii To th	Σ	29b. Signature and title of certifier	0 1			25	9c. Licens	e number		29d. Date sign		n, Day, Year)
•			30. Name and address of person who	completed cause of di	eath (Item)	23а) (Туре,	Print)		1488 6	25	SARC	30	-, 200°
	Sta	ate	31. Date filed (Month, Day, Year)	SARRERA 32. Registra	M.D ar's Signatu). 50	ON	IIPM	UKITLI	TVE. C	VIIIDEK	UNIVI	פום עווון נ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrative No. 180 Per FH6/25/09, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 19, Day 2009 Year 7:05 P.M Virginia MITZ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase Montgomery 5522 Uppingham Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth June 27 Year 1923 Philiadelphia, Pa 7. Age (In yrs. last birthday, Days Hours 1 □ M 2 □ **Y**F 85 193-20-3778 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20815 5522 Uppingham Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 💢 No Specify: White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (Firs Marres bia chrame) Rebecca Monspach David Rattin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Melville Ave., Palo Alto, Ca 94301 <u>Daniel Mitz</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Garden June, 22, 2009 Olney, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service L censes 254 Carroll St., N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Montell Seath Lung Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20815

June 22, 2009

Physician /Medical Examiner

certificate be executed

O. Box 68760.

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Division of Vital Records,

permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is r
any injury or other traur

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Md.

Funeral

Director

show

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "actical Examilinar must be netitined at

altimore, Maryland 21215-0036

Examine

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

Medical

3

Registrar

sician and burial-trans ing physician a Physician/Medical the signed by to be detach Completed by cate has I page 2 s this certific Be Certification: To After thi To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the propietely filled in by the funeral

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Month Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**Vo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

28c. Injury at Work?

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states.

29c. License number

D 39456

1 ☐ Yes 2 ☐ No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lila McConnell, M.D., 5530 Wisconsin Ave., #1400, Chevy Chase, MD

32 Registrar's Signature

Hospital:

5 Pending investigation

6 Could not be determined

JUN 23 2009

28a. Date of Injury (Month, Day, Year)

			For State	State o	f Marylan		artment of F		and Mental		-2.0	ng	21827
		_	Registrar 1. Decedent's Name (First, Midd	tle (ast)		- Cei	illicate of	Deain	2 Date	Reg. of Death	No.	00	3. Time of Death
	Physici		Queen Mills	, Lasty					Mont 6		Day 2	Year 1009	08:55A M
*	/Medio Examin		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, o	r Location o			4c. County		00.3011
-			Washington Ad	lventist Ho	ospital		Takoma	Park			MONTG	OMER	Y
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ xF	7. Age (In yrs. 67		If Under 1 Year Months Days	If Under :	Min. (Mon	of Birth th, Day, Ye.	ar)	9. Birth	place (State or Foreign ntry)
	Director		249-68-5069	I I WI ZLAN	07	Yrs.			1-19	- 1942		Sout	h Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. Count	y	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Mary -f sh fied a	ţo	DC		Was	hingto	n						1⊠Yes 2□No
	r 28a	irec	10e. Street and Number			· <u>-</u>	10f. Zip Code			10g.	Citizen of V	What Cour	ntry?
	th wit	Funeral Director	759 Nicholson	St NE			20011			U	SA		
	ems er m	ne	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	.S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify Yes . Puerto Rican, et	or No-		e - Americk, White,	can Indian, etc
36	or it	Ϋ́F	1 Never Married 2 Ma	rried 1 □Yes	2√∑No ve No		1 ⊡Yes 8x ⊡No	Specify:	,	. ,		BLA	
Ö	hours tural"	q p	3 Widowed 4 □ Divorce	d Year or D	ates:	16a Dooo	dent's Usual Occup	otion		166	. Kind of Bu		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, it a Modical Examiner must be notified at	Completed by	(Specify only high	nt's Education est grade completed)		(Give	kind of work done	during most d)	of working	100	, Kilia oi bi	usiness/in	dustry
212	with	E	Elementary/Secondary (0-12)	College (1 +1	-4or 5+)	1	opment St			t F	edera	ıl Go	vernment
b	al Hyg othe vent,	Be C	17. Father's Name (First, Middle	, Last)			•		r's Name (First, M		len Surnan	ne)	
ylaı	Menta	2	Enoch Floyd					Wille	rdean Da	vis			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at once.		19a. Informant's Name/Relation Ingermar Mills			i	ng Address <i>(Street</i> errapin T				-	State, Zij	o Code)
e,	1 and Healt em 2		20a. Method of Disposition		20h F				Date		Location -	City or To	own State
Baltimore,	ages int of t: If it		1 🙀 Burial 2 🗆 Cremation				sition (Name of natory or other place O VETERAN	is 0	6-25-200	1		•	MARYLAND
Ē	artme ortan injur		4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service		01	-		i .					Home LLC
Ba	permi Depa Impo any ir	et d	Juan Smith (June	Smil	30	05 12th S	Street	NE Wash	ingto			17
н			23a. Part 1. Enter the disease, of shock, or heart failure. Lie	complications that of t only one cause on e	aused the deat ach line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or respira	tory arrest,			Approximate Interval Between Onset and Death
1	hysician		Immediate Cause (Final disease or condition resulting in death)	_a. 111e	tastat	IC L	reast o	an	cor			1	Alyx
-	/Medical Examiner		rosulting in dodary	Due to	(or as a conseq	/	C 1						11.120
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	as a conseq		Janu	ce.				-	4mo.
	od dansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$									
o,	e exec ian an irial-tr	Exa	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):							
8760,	icate be executed physician and the burial-transit	dical		d									
Box 6	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ancy					23d. Da	te of deliv	erv
ĕ.	death e atte d for u	icial	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Preg	birth 2 Feta		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у				onth	Day Year
P.O.	t the by the lached	hys	9 ☐ Unknown	9 □ Unkr	nown								
Records, F	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Completed by P	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacc	co use cont	tribute to t	he cause of death?
ço	w requir s been s should	ete		,					24a	Was an	24h	Were auto	opsy findings available
Re	The law te has age 2 a				-				_	autopsy performed	3/	prior to co death?	empletion of cause of
Vital	lysician: The I iis certificate ha director, page	0 1	25. Was case referred to medic	al				26. Place	of Death (Check		√ 10]	1 □Yes	2 № No
_	Physici this cer al direc	70 B	examiner? 1 ☐ Yes 2X(No	Hospital:	Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Oth	or:	rsing Home 5		e 6 □ Oth	ner (Speci	fy)
u of	ng Pt fter tt neral	崩	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date (Mon	of Injury th, Day, Year)	28b. Time o	28c. Injur Wor	ry at k?	28d. Des	cribe how it	njury occur	red	
Sio	tendii eath. or: A the fu	cati		tigation	-5		M 1 □	Yes 2	No				
Division	or At after d Direct in by	Certification:		mined 28e. Place buildi	of Injury - At he ng, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Loca City	tion (Street or Town, S	tand Numb tate)	per or Run	al Route Number,
ш	pital		29a. Certifier	ing Physician: To the	hest of my kno	wiedne deat	h occurred at the ti	me date ar	nd place, and due	to the caus	e(s) and m	anner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		I Examiner: On the b	asis of examina ner stated.	ation and/or in	vestigation, in my	opinion, dea	th occurred at the	time, date	and place,	and due t	o the cause(s)
	Vithi Comp	ž	29b. Signature and title of certific				29c. Licens	1.00	101	29d.	Date signe	d (Month,	Day, Year)
	21			K			ML	7686	86		061	20	1200
	2		30. Name and address of person	who completed caus	se of death (Iter	m 23a) (Type,	Print) 21 Media	10.	In S	4.4	1200	1	10- Sim Mn
	Sta	to	31. Date filed (Month, Day, Year) 32. F	Registrar's Signa	ature	1 /1/EMG	il pui	WUYD	vileff	200	-311/	wifery 1 W.
	Registr		.1111 2 4 2	009 Senal	w A.	fac							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of	Marylan		rtment of F tificate of i			giene Reg. No.	000	21828
			Registrar 1. Decedent's Name (First, Middle, Las	t)			imodio or i		2. Date of De	ath	000	3. Time of Death
	Physicia /Medic	_	Myrna Lorett	3.6 77	innon				June 2	1 Day 2	200 ^{Ye ar}	5:34 a ^M
	Examin		4a. Facility Name (If not institution, give	street and numb	per)			r Location of Deat	h		unty of Death	
p.T			Southern Maryland			a a 4 birdb da . i)	Clint If Under 1 Year	on If Under 24 Hrs	9 Date of Bir		nce Geo	rges lace (State or Foreign
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9X □ M 2 🗆 X F	. Age (In yrs. I 62	Yrs.	Months Days	Hours Min.		y, Year) 1947	Coun	yana
	D .		Usual Residence of Decedent		140 67	T					1.1	0d. Inside City Limits
	arylar show	ž	10a. State 10b. County			, Town or Lo						1 □Yes 2 ^M No
	he M 28a-f outfle	Director	MD Prince G	eorges	Su	itland	10f. Zip Code			10a. Citizen	n of What Coun	itry?
	with with a		5902 Suitland Rd				20746			U	SA	
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. \	Vas Decedent of H		Specify Yes or No	- 14.	Race - Americ Black, White, e	
ဖွ	after or ite		1 ☐ Never Married 2 🖾 Married	Armed Force 1 ☐ Yes 2 If Yes, Give	X No		ires, specify Cub. I∐Yes 2⊠No	Specify:	to ricali, etc.)		necify:	
003	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, it e Modical Examinet must be notified at	d by	3 Widowed 4 Divorced	Year or Date	es:	160 Dage	dent's Usual Occup	nation			of Business/Inc	
<u>.</u>	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Give	kind of work done OO NOT use retired	during most of wo d)	rking		ndria (
212	withii jene. r than	omp	Elementary/Secondary (0-12)	College (1-4 5+	lor 5+)	Teach	ner				c Schoo	-
פַ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)						me (First, Middle	, Maiden Sui	rname)	
<u>/lar</u>	uld be Ments Ments arked	ToE	unknown			_		Ursula				
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examination to the traumatic event, it allocates and the continuation of the continuation o		19a. Informant's Name/Relationship (1 5902	ng Address <i>(Street</i> 2_Suitlan	d Rd.		er, City or To	own, State, Zip	Code)
≥ (a)	and tealth		James McKinnon -	Husband	20h P	Suit	land, MD	20/46	Date	20c. Locat	tion - City or To	wn, State
وّ	ages nt of h :: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐		ate		sition (Name of natory or other place		5-2009		phi, MD	
Ħ	artme artme ortant injura		4 ☐ Donation 5 ☐ Other (Specification of Specification o		Geo		shington . Name and Addre arshall s	1				-
Ba	Dep any any	1	Dagath &	- 10	ا دسم	_ 43	308 Suit1	and Rd.	Suitlar	nd, MD	20746	5
			23a. Part1. Enter the disease, or communication shock, or heart failure. List only	ólications that car	used the death	n. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	· m	1651 W			24-5	En low	m		Onset and Death
1	/Medical		resulting in death)	Due to (o	r as a conseq					- 66		
	Examiner	<u>_</u>	Sequentially list conditions,	b	r as a conse	uence of):						
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to to	as a conse	derice or).						
	execunand nand ial-tra	Examiner	that initiated events resulting in death) Last	CDue to (o	r as a conseq	uence of):						
8760,	ficate be executed physician and sthe burial-transit	dical		d								
89	rtifica ng ph as th		IF FEMALE:				-			·	1000	
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		rth 2 🗆 Feta	Ideath 3	Ectopic pregnan	су		230	 d. Date of deliv Month 	rery Day Year
	0 0 0	/sici	1 ☐ Yes 2 ☐ No 9 ② Unknown	4 ∐ Pregna 9 ∏ Unkno	ant at time of o wn	ieath 5 L	Other (specify) _	 -				
<u>.</u>	The law requires that the ate has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to dea	ath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?
g	uires n sign ld be	d by							. 10	Yes 2□	No 3□ Pro	bably 45 tinknown
Records,	w require s been się should b	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
æ	The law ite has age 2 s	omg							auto perf 1 □Yes	ormed?	death?	•
Division of Vital	ysiclan: The lis certificate hidirector, page	BeC	25. Was case referred to medical examiner?					26. Place of De	eath (Check only	2		
<u>></u>	Physic this ce al direc		1 ☐ Yes 2 No			ER/Outpatie	nt 3 LI DOA		Home 5 ☐ Res			fy)
u o	ding Ph h. After thi funeral	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		f Injury <i>n, Day, Year)</i>	28b. Time o Injury	Wo	ıryat rk?]Yes 2.∐No	28d. Describe	how injury o	occurred	
Sic	l or Attend after death Director:	icat	2 Accident investigation 3 □ Suicide 6 □ Could not b	e 28e Place o	of Injury - At he	ome. farm. sti	reet, factory, office	1162 2 110	28f. Location	(Street and I	Number or Rui	ral Route Number,
<u>≥</u>	after after Direct	Certification: To	4 ☐ Homicide determined	buildin	g, etc. (Special	fy)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		
	Hospita 24 hours Funeral etely filled		29a. Certifier (Check only 2 Medical Exa	ysician: To the h	best of my kno	owledge, deal	th occurred at the to	time, date and pla	ce, and due to th	e cause(s) a	and manner as	stated. to the cause(s)
1_	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	Medical	one)	and mann		and and of II					signed (Month	
7	To the within To the compl	2	29b. Signature and title of certifier				29C. Licen	se number	<	Zau. Date	5 / 2 3 /	-3
	4		00 N		of de-Ab //s	n 00c\ /=	Drint)	MUD.)	/	1 4 3/	0 4
			30. Name and address of person who	TS/	3 CI (Iter	rradit	R	alint	on Mo	1 20	734	
	Sta	to	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature .		~~~~	01./1111	4 9 -	4	

Registrar
DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 8:15 p M 2009 June 21McDermon Martha Morton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Temple Hills Prince Georges 3913 Triton Ct. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) **Funeral** Days Year. Hours Min. 1 □ M 2 🛛 F 79 June 11 1930 VA Director 226-30-7025 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Temple Hills Prince Georges 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 USA 3913 Triton Ct. Funeral 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify. Specify: þ **Black** 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4or 5+) 2+Elementary/Secondary (0-12) Bureau of Engraving Note Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Andrew Wesley White unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any injury or other trau Temple Hills, Md. 20748 3913 Triton Ct. Michael Alan McDermon-Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem 6-29-2009 4 □ Donation 5 □ Other (Specify) Suitland, MD. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Malignant Neoplasm Pancreas /Medical Due to (or as a consequence of): Examiner Malignant Neoplasm Colon Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conscouence off Examiner law requires that the death certificate be executed Due to (or as a consequence of) burial Box 68760, physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) ☐Yes 2 No P.O. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð t □ Yes 2 X No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe certificate 1 ☐Yes 2 K No 1 ☐ Yes 2X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Puneral Director: completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Morjth, Day, Year) 29b. Signature and title of certifier 29c. License number 14 (06666

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		-	For State of N State of Registrar	laryland / Depa <i>Cel</i>	artment of H rtificate of L			ene g. No. 🤈 🕦	00	21020
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	Year	3. Time of Death
	Physicia /Medic		Jorge A. Melgar				June 22	-	Teal	11:30 p M
į	Examin		4a. Facility Name (If not institution, give street and numbe 6417 Landover Rd. #T-4	r)	4b. City, Town, or Cheverl			4c. County of		orges
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)		-	8. Date of Birth (Month, Day, Jan. 2, 1	Year)	Country	ce (State or Foreign
н	Director		590-74-5926 1X M 2□F Usual Residence of Decedent	50 Yrs.			Jan.2,1	959	Guate	mala
	yland now at		10a. State 10b. County	10c. City, Town or Lo	ocation			_	10d.	Inside City Limits
	e Mar 3a-f sh tified	ctor	Maryland Prince Georges	Cheverly						1X Yes 2 No
	with th	Dire	10e. Street and Number 6417 Landover Rd. #T-4		10f. Zip Code 20784			0g. Citizen of W Guatema		' '
	be filed within 72 hours after death with the Maryland Hylgiene. dra Hylgiene. dra chter than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director		nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp		14. Race	e - American k, White, etc	
92	s after , or ite amine		11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Yes 2 Married 3 □ Widowed 4 □ Divorced 1 □ Yes 2 Married 1 □ Yes 2 Married 2 Narried 2 Married 2 Married 3 □ Widowed 4 □ Divorced	Νο	1 🛣 es 2 🗆 No	Specify: Guat		Specify.		
21215-0036	2 hours atural' cal Ex	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		 16b. Kind of Bu		
215	ithin 72 te. ian "na Media	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	r5+) l .	kind of work done of DO NOT use retired))	ang	Republ	ia co	razione
7	filed wi Hygier ther the	Cor	17. Father's Name (First, Middle, Last)		ntenance	18. Mother's Nam	e (First, Middle, I		*	r ATCE2
-	40 - 0 2	To Be	Jorge M. Melgar			Maria '	Teresa	Paredes	;	
lary	2 shou and N is mar		19a. Informant's Name/Relationship (Type. Print) (spo	. 1	ing Address (Street a			-		ode)
e, S	1 and Health em 27 ther tr		Silvia A.Sanchez-De Melgar		7 Landover osition (Name of ematory or other place			20c. Location -		n, State
altimore,	Pages ent of nt: If its		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)		inatory or other place Lo General	6/29	/2009 A	matitla	ın,Gua	temala
Baltii	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of uneral Service Licensee		2. Name and Addres	r.e	ndon/Hal			me
	2.2		23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not en					A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	iver Cancer						Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):						
8		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or firliny that initiated events	as a consequence of):						
	ecuted and -transi	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or.	as a consequence of):						
68760,	cate be executed physician and the burial-transit	al E	d d	ao a concequence e.,.						
		Medical	JE SEMALE:							
Box	ath ce ttendir or use	Physician/M		n 2 □ Fetal death 3	Ectopic pregnancy	/			te of delivery onth D	ay Year
0	the de y the a iched f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnan 9 ☐ Unknown 9 ☐ Unknown		Other (specify)					
s, D	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by Pr	Part II. Other significant conditions contributing to death	h but not resulting in the t	underlying cause giv	en in Part I.				cause of death?
ord	w requir been si should I						1 ☐ Y			bly 4 Unknown sy findings available
Bec	he law e has b	Completed					autop:	sy med2	prior to comp death?	pletion of cause of
<u>ta</u>	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea	1□ Yes th Check on or		10163 2	
or <	Attending Physician: r death. ector: After this certification of the funeral director, by	2		atient 2 ER/Outpatie	1	4 LI Nursing H	ome 5 Resid	ence 6 Oth		
OUO	th. After funer	tion:	1 2 atural 5 Pending (Month, 2 Accident investigation	Day Year) Injury	Wor	yat k? Yes 2 ∐ No	200. Describe ii	ow injury occur	Cu	
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law within 24 hours after cleath. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, farm, s , etc. (Specify)	treet, factory, office		28f. Location (S City or Tow		er or Rural I	Route Number,
Ω	spital cours af leral D		29a. Certifier 1 ☐ Certifying Physician: To the be	est of my knowledge, dea	ath occurred at the ti	me, date and place	, and due to the o	cause(s) and ma	anner as sta	ted.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the basi and manner	s of examination and/or i	investigation, in my	opinion, death occu				
	To the vithin To the company of the company of the the company of	Ž	29b. Signature and title of certifier	PHYSIC	29c. Licens	e number	2	29d. Date signe	d (Month, D	lay, Year)
Ì	1/		30. Name and address of person who completed cause	of death (Item 23a) (Type	Print)	70061	507	6/2	5/200	3
R	- 4		Naimish Pandya, MD 22 S	. Greene St.		re, MD 21	201			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 5 2009	strar's Signature						

	7 - State Registrar		Cer	tificate of	Death		Reg. No.	UUY	2183
Physician	1. Decedent's Name (First, Middle FLOYD	, Last) MCRAE		JR.		2. Date of De Month	Day	Year	3. Time of Death
/Medica	I LOID				r Location of Death	JUNE	19 200 4c. County		9:40 A M
Examine	FT. WASHINGTON		İ		SHINGTON	1			ORGE'S
Funeral		6. Sex 7. Age (In yrs. I	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birthpla	ace (State or Foreign
Director	578-56-8943	1 2 M 2□ F 65	Yrs.	Michael Days	Tiodis Will.	OCT. 0		SOUTI	H CAROLINA
and	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10	Od. Inside City Limits
Maryl.	MD PRINCE	GEORGE'S F	ORT WA	SHINGTON					1. Yes 2 □ No
r 28a	MD PRINCE 10e. Street and Number	OLOROZ 3		10f. Zip Code			10g. Citizen of	What Count	:ry?
th with		ROAD		20	744		USA		
r dear	11. Marital Status 1 □ Never Married 2 ☒ Marrie	12. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14. Rad Bla	ce - America ck, White e BL	an Indian,
	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 ANo If Yes, Give Year or Dates:	1	□Yes 2 No	Specify:		Specif		ACK
2 hour	15. Decedent	's Education	16a. Deced	lent's Usual Occup	pation		16b. Kind of B	usiness/Ind	ustry
hin 72 an "na Matik	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12th	t grade completed) College (1-4or 5+)	(Give)	kind of work done OO NOT use retire	during most of wor d)	king	COUNT	v cov	ERNMENT
od with sear the control of the cont	512th		CUSTO	DIAN ENG					
e datale	17. Father's Name (First, Middle, I	Last) SR•			18. Mother's Nan		, Maiden Surnar	ne)	
2 should be filed within a not what and Mental Hygiene. Is marked other than raumatic event, the Manamatic event even	FLOYD MCRAE 19a. Informant's Name/Relationsh		10h Mailin	a Address (Street	and Number or Ru	ural Pauta Numb	or City or Town	State 7in	Cadel
Ma d 2 s d 2 s th ar thau trau	GERMAINE MCRA				EW ROAD F				
permit. Pages 1 and 2 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other transfer	20a. Method of Disposition	20b. P		sition (Name of natory or other pla		Date	20c. Location		
Pages nent o int: If	1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other S	3 Li nemoval nomi state		ON NATION		5/2009	SUITLAN	ID,MAR	YLAND
Definition Pages Department of Important: If it any Injury or of Important or	21. Signature of Sumeral vervice		22	. Name and Addre	ess of Facility $ {\sf J} . $				
0 89 8 8 8	10.	100		7474 LANI	OOVER ROA	D LANDO	VER, MAR	YLAND	20785
	shock, or heart failure. List	complications that caused the deatl only one cause on each line.	h. Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)	PULMONARY 1	EDEMA						
/Medical Examiner	recenting in deadily	Due to (or as a consequence CONGESTIVE		EATTIIDE					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CUNGESTIVE		FAILURE					
cuted and ansit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	HYPERTENSI	ON						
e exection arriginal trial tr		Due to (or as a consequence	uence of):					Ĩ	
certificate be executed nding physician and use as the burial-transit	IF FEMALE:	d. DIABETES						-	
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	in the past 12 months?	1 Live birth 2 Feta	Ideath 3 □	Ectopic pregnand Other (specify)	су		1	ate of delive onth	Day Year
the d	1 Yes 2 No 9 Unknown	9 Unknown							
ding Physician: The law requires that the death h. After this certificate has been signed by the atter funeral director, page 2 should be detached for the control of the c	Part II. Other significant condition	ons contributing to death but not resi	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cor	tribute to th	ne cause of death?
law requires that some as been signed as should be considered.	HYPERLIPIDEM	IA				1 🗆	Yes 2 □ No	3☐ Prob	pably 4 Unknown
law re as be 2 sho	B HIPEKLIPIDEM					24a. Was	an 24b.	Were autop	psy findings available mpletion of cause of
The The page	E					perfe	ormed? 2 X No	death? 1 □Yes	
VICAL Ician; T	25. Was case referred to medical examiner?	Henritali			26. Place of Dea	ath (Check only	one)		
Physical direction		Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien	IL 3 LI DON		1	idence 6 00 how injury occu		y)
ding h.	1 Natural 5 Pendin	g (Month, Day, Year)	Injury	Wo	rk?]Yes 2□No	Zod. Describe	now injury occu	ileu	
l or Attending Phy after death. Director: After this in by the funeral d	2 Accident Investig	not be 28a Place of Injury - At he	l pme, farm, stre		100 20.00	28f. Location	(Street and Num	ber or Rura	al Route Number,
all or /	27. Manner of Death 1 Natural 2 Accident investig 3 Suicide 6 Could reference 4 Homicide	building, etc. (Specif	(y)			City or To	wn, State)		
		g Physician: To the best of my kno Examiner: On the basis of examina							
the Hin 24 the Fi	orye)	and manner stated.	ation and/or in			arred at the time			
To To To on	29b. Signature and title of certifie	//11		29c. Licen			29d. Date sign	ed (Month,	⊔ay, rear)
~		ι'		D14	.OI2		0/22/0	1	
25	30. Nameland address of person	who completed cause of death (Item ADI M.D. 6230 OXC	n 23a) (Type,)N HTT.T	ROAD #	204 OXON	HILL,MAI	RYLAND	20745)
State	31. Date filed (Month, Day, Year)	20 Pagietrar's Signs	turo						
Registra		Beneva B. A.	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	lental Hygier Reg. ۱		01000							
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	7 4 4 4 4 4	3. Time of Death							
	Physici		Dimples Luvetta Miles		Pay 2009	0647 M							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		c. County of Death								
	LAGIIII	e e	PENINSULA REGIONAL MEDIEN CENTU SALISBURY		HIOMIC	O							
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthpl Count	ace (State or Foreign							
	Director		215-09-6532 1 N 2 F 95 Yrs. Months Days Hours Min.	6-26-191	3 MD	' 97							
	P .		Usual Residence of Decedent										
	how	_	10a. State 10b. County 10c. City, Town or Location		110	d. Inside City Limits 1X Yes 2 □ No							
	e Ma	cto	MD Somerset Crisfield										
	or 28	Director	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Count	ry?							
	th wi	la	Somers Cove, Apt 33 21817		S.A.								
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show ofter Examiner must be rediffed at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e								
36	afte or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		Specify:								
8	ural",	d by	3 □ Vidowed 4 □ Divorced Year or Dates:	101	Specify								
21215-0036	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)		Kind of Business/Ind	ustry							
121	filed within Hygiene. wher than "	ш	Elementary/Secondary (0-12) College (1-4or 5+)		afood								
	Hed v Hygie her i		8th Seafood Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid									
an G	should be filed wand Mental Hygie is marked other taumatic event, In	Be	, , , , , , , , , , , , , , , , , , , ,		on comanic)								
3	J Me J Me Jark	은	Edward Lankford Hattie		Canada Tin	0-4-1							
Maryland	2 sho h and r is ma	W 8	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Run 100 C. D. J. J. L. L. C. L.										
e, 1	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Mexical Extensi errunal be rediffed at	1 3	Luvetta Tate/Granddaughter 1206 Falconett Ct, 20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or To	MD 20//4							
Ö	ges If it	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Cemetery, crematory or other place) 20c. Location - Cemetery, crematory or other place)											
Ħ	t. Pa tmer tant: ijury		4 □Donation 5 □Other (Specify) Lane Family Cemetery	La	wsonia,	MD							
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature pt Kuperal Service Licensee 22. Name and Address of Facility Bennie Smith 9	17 W. Is	abella S	t							
_	a_o				, MD 218								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death							
may .	Physician		Immediate Cause (Final disease or condition										
	/Medical Examiner		resulting in death) Due to (or as a consequence of):										
	Lxaiiiiiei	L	Sequentially list conditions. b. Blateral Preumona										
	ed sit	ine	Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or Injury that initiated events C. Active Perul Fallure										
	ecut and -tran	Examiner											
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68760,	icate be executed physician and the burial-transit	edical	d. 1611/100 (Visited ())										
9 ×	ding page as		IF FEMALE:										
Вох	eath certif attending for use as	ian/	23b. Was decedent pregnant in the past 12 moprins?		23d. Date of deliver Month	ry Day Year							
<u>o</u>	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify)										
σ.	res that the de signed by the a be detached to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e, Did tobaco	o use contribute to the	e cause of death?							
of Vital Records,	signe	þ		1 □ Yes	2 No 3 Prob	ably 4 Onknown							
0	w requir been s should	Completed											
ě	e law has t e 2 si	hgu		24a. Was an autopsy	prior to cor	osy findings available npletion of cause of							
E E	ician: The certificate h ector, page	S		performed 1 □ Yes 2 🗷		2 □ No							
/its	cian sertifi ector,	Be	examiner?	th (Check only one)									
£	Physical this caracteristics	၉			6 ☐ Other (Specif	<i>(</i>)							
ב	ding F h. After funera	ü	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how in	njury occurred								
Division	Attendi er death. rector: / by the fi	Certification:	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home farm street factory office.										
≥	or Attencate after death Director:	ij.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, St	t and Number or Rura tate)	I Houte Number,							
	urs a					A-AI							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examinery On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)										
	the the mple	Med	, and marrier stated	204	Date signed (Month	Day Year)							
	5 ≥ 5 8		250. Cignatura and the of contribut	1-	114 mg -	SIE							
	B-NA		130069+58	01	1110/0	7-500							
	NO-C.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	51.		1/9.							
			ALI SABERI N.). 100 E. Carrou ST.	YAUSBUR	ry Md	21001							
	Sta Registr		29b. Signature and attitle of certifier 29c. License number 1) 006 9 7 58 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALI SABELI N.). 100 E. Caccou St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Aparticular St.		•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Winifred Gwendolyn 1800 Medcalf /Medical 29 09 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ler 1 Year | If Under 24 Hrs. WMHS BRADDOCK CAMPUS ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 7, 1929 (State or Foreign 9. Birthplace (State Country) **Funeral** 1 □ M 2 □ 😿 Months Days Hours Min 213-26-1627 Director 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, Its Modical Examiner must be notified at MD Allegany Cumberland 1 □ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Seton Drive 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xo 2 If Yes, Give Year or Dates: Specify Specify. 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7; h and Mental Hygiene. 7 is marked other than "n; Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Bender Morrow Mary Catherine Taylor Morrow ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Travis Medcalf 147 Washington Street son Frostburg MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 🗀 Removal from State Scarpelli Funeral Home, P.A. 7/2/2009 MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 /arr . Enter the disease, of complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sp. ck, or nea/ failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONGESTIV dia ase or condition resulting in data.) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown δ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate performed Division of Vital 2 1 No 1 □Yes 2 1No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shiv 2NNA 1201 F.
32. Registrary Signature HWY. LAVAle NATIONAL 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June. 2869 Kay Davison Morrison 1623 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harkord 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/22/1942 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F Hours 219-42-2226 66 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Eventure must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD 1 ¥Yes 2 ☐ No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 98 Mount Royal Avenue 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No 2 Specify Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vaughn E. Davison Beatrice J. McPheron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy W. Morrison (Husband) 98 Mt. Royal Avenue, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co. Inc. 106/29/2009 | West these. ...
22. Name and Address of Facility Zellman Functal Home, P.A. 4 Donation 5 Dother (Specify) 06/29/2009 | West Chester, PA 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe prieumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MSCUS with peritoriti Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 1 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D63420 June 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zubair Kharal 501 Union Avenue. Havre de Grace, Maryland 21078 31. Date filed (Month, Day, Year) 32. Regintrar's Signature State Registrar

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DJr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** O'Dea 2009 JUNE ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Days **Funeral** _1 🔀 M 2 🗆 F Massachusetts 01/11/1945 64 Director 016-34-9610 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show. 10a. State 10b County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 1X Yes 2 □ No Director Washington DC death with the 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 20009 1725 New Hampshire Avenue NW by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) than Lawyer and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Carol Frances Gibbons James L. O'Dea Jr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 1401 Q St. NW #601 Washington, DC 20009 Thomas Cullen / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Metropolitan Cremat. 06/23/2009 4 Donation 5 Other (Specify) Alexandria, VA 21. Signaty of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. \$130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Tyocardial **Physician** disease or condition /Medical resulting in death) (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ig physician and as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 2 Accident Injury al or Attending s after death. I Director: Aft 1 Yes 2 No filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospital of 24 hours a Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

ID

To the I within 2

29b. Signature and title of certifie

Jeffrey

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

D 67226

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

06, 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 21, 2009 Year **Physician** Odum Mary 22:20 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Hospital Rockville Montgamery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F July 4, Director 126-38-2054 61 1947 New York Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Xes 2 ☐ No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 U.S.A. 13912 Dowlais Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xio Maryland 21215-0036 Specify: White Specify Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) les 1 and 2 should be filed within to Health and Mental Hygiene. If item 27 is marked other than "I other traumatic event, Inc Mex Elementary/Secondary (0-12) College (1-4or 5+) Accountant Internal Revenue Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Bernzott Frances Feldberg Pages 1 and 2 should ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80 Eith th Street #900 New York, New York 10011 Mary Ann Nichols-Kallus (friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If ite
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cem. July 31,2009 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rendon/Hale Funeral Home Whard 9013 Annapolis Rd. Lanham, MD. 20706 endar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ELANOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Was deceded... in the past 12 mont 1 □ Yes 2 2 No Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown s peen signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The lav age 2 autopsy performed? 1 □ Yes 2 No certific te 1 ☐ Yes 2 ☐ No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title

State Registrar

12

EPH

ddress of person who completed cause of death (Item 23a) (Type, Print)

D 35 635

1811/ Prince Philip DR DLNEY, MD 20832

			For State Registrar	5	State of	Maryland		artment o			d Me	ntal H	ygier Reg. N	00	0.0	2103
			Decedent's Name (First, Middle)	fle, Last)		_					2.	Date of E	Death			3. Time of Death
	Physici		Myrtle Blandf	ord	Parkei	:					Ι,	Month June	21,	2009	Year	10:10 a ^M
	/Medio Examin		4a. Facility Name (If not institution	on, give stre	et and numb	er)		4b, City, Tov	n, or Loc	cation of D				lc. County	of Death	
	Examin	er	Shady Grove Ad	, 0		,	Rehal		kvil					Moi	ntgon	nery
	Funeral		Social Security Number	6. Sex		Age (In yrs. I		If Under 1 Y	ear If	Under 24	Hrs. 8.	Date of E	Birth .	,	9. Birthpl	ace (State or Foreign
	Director		579-40-0388	1 🗆 N	1 2 X F	77	Yrs.	Months D	ays F	fours N	Min. F	Date of E (Month, i	14 , rea	1932	Ma 1	yland
			Usual Residence of Decedent									-				
	ylany		10a. State 10b. Count	у		10c. City	, Town or Lo	cation							10	Od. Inside City Limits
	Mar a-f s	혅	W.V. Je	effers	on		Char:	les Tow	'n							1 □ Yes 2 No
	h the	Director	10e. Street and Number					10f. Zip Co					10g. (Citizen of W	hat Coun	try?
	h with	<u>e</u>	77 Pebble Be	each C	Circle			2541	.4					USA		
21215-0036	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Eventing must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma Widowed 4 Divorce	rried	Was Decede Armed Force 1Yes 2 If Yes, Give Year or Date	X No		Was Decedent If Yes, specify	Cuban, N	anic Origin Mexican, P Specify:	? (Specif Puerto Ric	y Yes or I an, etc.)	No-	Black	- America k, White, e	etc.
2-0	72 ho	tec	15. Decede (Specify only high	nt's Educat	ion		16a. Dece	dent's Usual C	ccupatio	n na most of	working		16b.	Kind of Bu	siness/Ind	lustry
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Maryland	0 8 0 8	To Be (17. Father's Name (First, Middle Joseph Andre		andfor	Ē			18					en Surname H end		n
	permit. Pages 1 and 2 should bu Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relation Kelly E. Dubya					ng Address (S ebble I						,		*
Baltimore,	f He f He item othe		20a. Method of Disposition			20b. P	lace of Dispo	sition (Name on matory or othe	of r place)	i	Date			Location -	City or To	wn, State
30	ages ent o nt: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (noval from St	are		itan Cı		torv	Jun	e 22,	, ₂₁	Sucra	ris	Virginia
∄	artme ortar injur		21. Signature of Funeral Service		a	1100		Name and A								VIIGIIIIA
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V ACC	Physician /Medical		23a. Purt1 Enter the lisease, chool, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complica st only one	Meta:	th line. static	Breas		f dying, s					VCI 5		Approximate Interval Between Onset and Death 3 months
wali	Examiner				Due to (or	as a consequ	derice or):									
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7	ted 1sit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	540 (0 (0.	40 4 00110040	201.00 01).									
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	1 Live bir	me of pregna th 2 ☐ Fetal nt at time of d vn	Ideath 3	☐ Ectopic preg ☐ Other <i>(speci</i>						23d. Date Mor	e of delive	ery Day Year
	that ed b		Part II. Other significant condi	tions contri	buting to dea	th but not resu	ulting in the u	nderlying caus	e given li	n Part I.		23e. Di	d tobacc	o use contr	ibute to th	ne cause of death?
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to the funeral director.	Medical				is of examina		h occurred at vestigation, in								
	To the vithing to the total of the total of the	ž	29b. Signature and title of certif	er				29c. L	cense nu	umber			29d.	Date signed	(Month,	Day, Year)
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			Ravi Passi, I	D	15205	Shady	Grove	Road,	#208	B, Ro	ckvi	lle,	MD	20850		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20009 June 13, Robinson Angulia D. 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Community Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Vear) Hours Min. 1 □ M 2 🗓 F May 5,1962 Director 47 Carolina 577-04-2922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov 1X Yes 2 □ No Director District Heights Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5918 Addison Road 20743 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2K No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aid Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Robinson Dorothy Curry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Russell/Son 5918 Addison Rd. District Heights, MD 20713 Important; If item 27 any injury or other trong once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1

Burial 2 □ Cremation 3 □ Removal from State 6/20/09 Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. #278 3831 Georgia Ave. NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiomyopathy /Medical Due to (or as a consequence of) Examiner Myocardial Infraction Sequentially list conditions, it any least to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy detached for Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metastatic Uterine Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Symptomatic Anemia 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 🛣 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural s after death. 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Box 68760, P.O. of Vital Records, After **Division**

Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Bettie Lee Rhoten 1:06 p M 19 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hopsice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 22 7 Age (In vrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 2 19<u>34</u> Months Days 1 □ M 2 🖫 74 215-32-3000 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? items 23a or 823 Fairfield Avenue 21157 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 XNo 1 ☐ Never Married 2 M Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President/Secretary Rhotens Printing Co. is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carvel Horton Zelda Lindsay ဥ permit. Pages 1 and 2 shoul Department of Health and Milmportant: If item 27 is marl any Injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Fairfield Avenue Westminster, MD O. Bruce Rhoten/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 06/2472009 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Juneral Service License Fire so Fune and Chapel, P.A. Westminster, MD 21157 412 Washington Road 23a. 1 art 1. En at the disease, or complications that cau led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) TYPS 2 NO 9 Unknown this certificate has been signed I al director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature a 29d. Date signed (Month, Day, Year) 29c. License number NJL 20 Name and address of person who completed cause of death (Item 23a) (Type, Print) NOSTHILLSON, HD ZIIS7 to Cert Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Registrar JUN 23 2009 Leven S. Jacks.					Centus	1	bar	Med.					

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar			ylana / D	Certif	icate of	Death	7		Reg. No.	2009	2	1842
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7	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birti		Under 1 Year	If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	th	9. B	irthplace (8	State or Foreign
	Director		577-46-1081	1 □ M 2 🕱 F		74	rs. Mo	onths Days	Hours	Min.	April			Mary1	and
	and sw		Usual Residence of Decedent 10a. State 10b. Count	ty	1	10c. City, Town	or Location	on	***	-				10d. Ins	side City Limits
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	r dea:	Funeral Director	11. Marital Status	12. Was Dec Armed Fo	orces?		13. Was	Decedent of s, specify Cu	Hispanic C ban, Mexic	Origin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-	14. Race - An Black, Wh		ian,
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jirel Examiner must be notified at		1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🗷 Divorce	If Yes G	ive		1 🗆 '	Yes 2 🗷 No	Specif	fy:			Specify:	Cauc	asian
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Ĕ	hould id Me mark maric	ဍ	19a. Informant's Name/Relation	d Ginsberg		19h	Mailing A	ddress (Stree	et and Num	her or Rura	al Route Numb			Zip Code)
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altimore,	Page nent c int; if		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other		State	·		Cemete		06/23	/2009	Охе	n Hill,	Mary1a	ınd
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee	20	'	Hin	ame and Add es-Rina	ldi Fu	eral H	lome, Inc	vor S	nring N	larvl an	od 20904
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			30. Name and address of person	•						10 D-		/ Marrie	4 2005		
	Sta	to	John S. Saia 31 Date filed (Month, Day, Yea			L Seven L 's Signature	OCKS .	koad, Si	11te 20	JZ, KOC	KVIIIe,	riaryl	and 2085		
	Sta Registi		JUN 23		244	A	back								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 10:35 AM June 20, William Allen Shea /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Montgomery Potomac Manor Care Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Min. 1 X M 2 □ F 10/03/1936 Washington, DC 72 Director 578-44-8641 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County 1X Yes 2 ☐ No DC Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20015 United States 2971 McKinley Street NW Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ⊠Yes 2 No 1956— If Yes, Give Year or Dates: 1959 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government Investigator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmund T. Shea Marjorie A. Allen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18811 Porterfield Way Germantown, MD 20874 Tom Shea / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition t of F : If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department o Important: If i any injury or Gate of Heaven Cemet. 06/26/2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Ser 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 □No 2 D 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO054566 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annue # 1-17, Filver spring 9 for Changia Sunidtra Blogavilli,

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 23

32 Registrar's Signature

09-04823 Tae Kyo Seo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

-		- For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cert	ificate of	Death		Re	g. No.	09 21041
Physicia	n/	Decedent's Name (First, Midd	lle,Last)					Date of Deat Month	Day Year	3. Time of Death 0321 hrs
Medical Examin		Taekyo	Seo		- 14	h City Town or	Leastion of Doot	June 18, 2	4c. County o	
		4a. Facility Name (if not institution Frederick Rd & Runni	ing Brook Dr			Clarksburg	Location of Death		Montgon	nery
Funeral Director		5. Social Security Number 215-79-5745		je (In yrs. las 18	st birthday) Yrs.	If Under 1 Year Months Day				Birthplace (State or Foreign Country) Korea
á		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Location	on				10d. Inside City Limits
how a		MD Mont	gomery		Boyd	le				1 Yes 2 X No
daryland 28a-f show any 1 at once.	Director	10e. Street and Number	gomery	1	Боус	10f. Zip Code		10	0g. Citizen of Wh	at Country?
the M	١	21723 Seneca A	yr Drive			2084	.1		Korea	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	1 Yes 2		If Ye	es, specify Cuba	spanic Origin? (S n, Mexican, Puerto		White	
ral", c	ğ.		vorced If Yes, Give Year or Dates:			Yes 2 X No	specify:	work done	Specify: £	Asian
hours	ted-	15. Decedent's Education (Spe Elementary/Secondary (0-12)					e. DO NOT use ref		TOD. KING OF BUS	siliess/ilidustry
336 thin 72 re. than edical	Completed	12		- /	Stud	lent			High S	chool
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle	, Last)				18.Mother's Nam	e (First, Middle, M	Maiden Surname))
121 d be fi ental I arked	8	Sang Hyuk Sec 19a. Informant's Name/Relation			10h Mailine	Addrona (Cta		nsung Ha		n, State, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	۵	Sang Hyuk Seo			W.	•	Ayr Driv			
e, M and 2 Health item 2	ŀ	20a. Method of Disposition			lace of Disposi	tion (Name of ce	emetery,	Date		City or Town, State
nord ages I art of I	-		n 3 Removal from St	Met	rematory or oth ropolit Crema	er place)	Ju 20	ne 20 109	Alexand	ria, Virginia
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service	e Licensee		22. N	ame an Addres	s of Facility			
		Ceutus E & 23a. Part I. Enter the disease, o	ry molli	16	De	/ol Fune	ral Home Gaithe	rsburg,	MD 2087	Park Drive, 7 Approximate Interval
Physician // // // // // // // // // // // // //	ļ	23a. Part I. Enter the disease, o failure. List only one cause	e on each line.		Do not enter tr	ie mode of dyling	, such as cardiac	or respiratory air	est, shock, or nea	Between Onset and Death
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)	e a. Multiple Injuries Due to (or as a cons):					
I.P		Sequentially list conditions,	b							
	j.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	sequence of)):					
B ted	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of)):	-	-			
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED							
760, icate be of physicia the buria		IF FEMALE: 23b. Was decedent pregnant in:	23c. If yes, outco	me of pregn		and do oth 3	Ectopic pregr	ancy	23d. Date of Month	delivery Day Year
that the death certificate by the attending detached for use as	Physician	past 12 months?	4 Pregnant a	t time of dea	_ =	tal death 3 ner (S <i>pecify)</i>		iancy	World	Day Tour
BO) e deatl the atl	hys		nknown 9 Unknown					OO- Did.		ibute to the cause of death?
Division of Vital Records, P.O. Box 68' tall or attending Physician: The law requires that the death certifiers after cleath. "I Director: After this certificate ha been signed by the attending lied in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant cond	itions contributing to deal	th but not re	sulting in the u	inderlying cause	given in Part I.			Probably 4 Unknown
ds, leaduires				<u> </u>				24a. Was		Were autopsy findings available
COL lav re ha b	Completed				<u> </u>	<u>-</u>			rmed?	orior to completion of cause of death?
Re ifficate or, page	Ŝ	25. Was case referred to medic				26.Plac	ce of Death (Check	1 Yes	2NO	Yes 2 No
of Vital ng Physician: ufter this certif neral director,	, B	examiner? 1 ✓ Yes 2 No	Handtel	ient 2	ER/Outpatient	з 🗌 роа	Other Nurs	ing Home 5	Residence 6	✓ Other: Scene
of Vital Reing Physician: The After this certificate to be a constitute of the certificate to be a constitute of the certificate 盲	27. Manner of Death	28a. Date of Inj (Month, Day) Jun 18, 2005	jury Year)	28b. Time of 1 0312 hrs	· · ·	ury at Work?		how injury occurr in auto-fixed	ed object collision	
sion (ttend) death. ctor:	igi jati		estigation				Yes 2 ✔ No	000 1	Otes et ee d Norsk	as as Diseas Decido Number City
Divis	Certification:	det	uld not be 28e. Place of I (Specify) Lo			et, factory, office	building, etc.	or Town, S	State)	er or Rural Route Number, City ook Dr, Clarksburg , MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		4 Homicide	Physician: To the best of n			red at the time,	date and place, ar	-		
o the Fithin 2.	Medical	one) 2 Medical Ex	caminer: On the basis of exa	amination an	nd/or investigat	tion, in my opinio	on, death occurred	at the time, date	and place, and o	due to the cause(s)
3	Me	29b. Signature and title of certif		_			nse number			ed (Month, Day, Year)
		Carde,	Hellein			0.0	,М.Е. 		June 19, 2	
		30. Name and address of person Carol Allan, MD A	on who completed cause of ssistant Medical Exa			Street. Baltin	nore, MD 212	01		
St	ate	31. Date filed (Month, Day Year	r) 32 Registr	ar's Signatu	m 4					
Regist		JUN 23			bar	Les .				

09-05115 Pendora Sharp Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

endora	Sharp	1-		nent of Health and Mental H icate of Death	Reg. No	200	09 2184
	Physicia		egistrar . Decedent's Name (First, Middle,Last)		Date of Death Month Day		3. Time of Death
	l Examir	ner	Pendora Sharp		June 29, 2009		0316 hrs
A	Į.	4	a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center	4b. City, Town, or Location of Death Cheverly		c. County of Death Prince George	's
		E	5. Social Security Number 6. Sex 7. Age (In yrs. last		s. 8. Date of Birth(MN	M/DD/YYYY) 9. Birt	hplace (State or
	Funeral Director		577-50-7225 1 M 2xF 70	Months Days Hours Mir	Nov. 3,	1938 Foreign	untry) SC
		-	Jsual Residence of Decedent		1100.033		10d. Inside City Limits
	y any		0a. State 10b. County 10c. City, To	wn or Location			1 X Yes 2 No
	land f shov	<u>ā</u> l	Maryland Prince George	Capitol Hei	ghts	citizen of What Cour	
0	ne Maryland or 28a-f show fied at once.	Director	I De. Street and Number	20743		United S	
2	with the Maryland ns 23a or 28a-f sho be notified at once.		912 Balboa Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri	can Indian, Black,
1	hours after death with the Maryland 'natural", or items 23a or 28a-f sho Examiner must be notified at once	- I	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	to Rican, etc.)	White, etc.	rican
	after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Curati dana 16h	Specify: Am Kind of Business/	erican
	hours natur Exami	be	10. 20044.10	 Decedent's Usual Occupation (Give kind of during most of working life. DO NDT use re). Nilly of business.	industry .
36	uin 72 E. than " dical	bet	Elementary/Secondary (0-12) College (1-4 or 5+)	Homemaker		Self-	Employed
215-0036	led with Hygiene other t	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nan	ne (First, Middle, Maid	en Surname)	
215	uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	Be	James Parlor	19b. Mailing Address (Street and Number o		City of Town State	Zin Code)
D 21	hou is n	٢	19a. Informant's Name/Relationship (Type, Print)	2311 Brooks Dr., _#		land, Md	
, MD	alth m	617		ace of Disposition (Name of cemetery,	Date 20	c. Location - City or	Town, State
ore	등분들회		1 X Burial 2 Cremation 3 Removal from State		uly , 2009	Cheltenh	nam Md
Baltimore,	permit. Page Department o Important: injury or oth	H	4 Donation 5 Other Specify: M2 21. Signature of Fu eral ervic Lice	22. Name and Address of Facility	tewart Fun	eral Home	, Inc.
å	Dep Dep		What is relucioned	\ \ 4001 Benning Rd.	NE Washi	ngton, DC	20019 Approximate Interval
	rysician Medical		23a. Part I. Enter the disease, or complications that caused the death. If failure, list only one cause on each line. Complication limmediate Cause (Final disease a. With hypertens)	ons of sickle cell di	sease asso	ciated	Between Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ive cardiovascular di extraction of teeth	sease stat	us post_	1
			Sequentially list conditions,				
		ner	if any, leading to immediate Due to (or as a consequence of):				
		Examiner	(Disease or injury that initiated events resulting in death) Last				
	te be executed hysician and e burial - transit		d. 20b nerki	0894 8/26/09 TT			
ć	certificate be executed nding physician and ise as the burial - transi	Medical		n g894 8/26/09 TT perME, g897 11/17/09	Tr	23d. Date of delive	any.
976	ificate ig phy is the b	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnation the like i	ancy 2 Fetal death 3 Ectopic pre	gnancy	Month	Day Year
9 X	th cert trendi	icia	past 12 months? 4 Pregnant at time of dea 1 Yes 2 ✓ No 9 Unknown 0 Unknown	th 5 Other (Specify)			
<u> </u>	The law requires that the death cate has been signed by the atter page 2 should be detached for u	Physician/N	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
O. O.	s that gned b e detac	ρ			1 Yes	2 ✓ No 3 Pr	obably 4 Unknown
ds.	equire een si ould b	eted			24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
ç	e law r e has b ge 2 sh	Completed			performe	ed? death?	?
8	n: Th tificat or, pag	ပ္တို	25. Was case referred to medical	26.Place of Death (Che	eck only one)		
Vita	ysicia this cer direct	To Be	THE Z INO			esidence 6 Oth	ner:
ò	After uneral	Ë	(Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how	w injury occurred	
ion	Attend death. ctor:	atic	2 Aid4 Investigation	me, farm, street, factory, office building, etc.		eet and Number or	Rural Route Number, City
Division of Vital Records, P.O. Box 68760,	piral or Attending Physician: The law requires that the death certificate ours after death. reral Director: After this certificate has been signed by the attending phyfiled in by the funeral director, page 2 should be detached for use as the	Certification:	Suicide 6 Could not be determined (Specify)	me, fami, street, factory, office building, oto.	or Town, Star		
_	E 2 5 E	_	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledg	e, death occurred at the time, date and place,	and due to the cause(s) and manner as s	tated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	nd/or investigation, in my opinion, death occurr	ed at the time, date an	id place, and due to	(the cause(s)
	F 5 F 5	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(f</i> June 30, 2009	
			D_m_m				
R			Name and address of person who completed cause of death (Item Donna M. Vincenti, MD		, MD 21201		
) State	31. Date filed (Month, Day, Year) 32. Registra 's Signa to				
	Pagi		1111 0 0 2009 / hard 10. 19.				

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		-	For State Registrar	State of Mar		Department of F Certificate of I			giene Reg. No. 🥎 🅜	100	0.101.6
88			Decedent's Name (First, Middle, La	ist)				2. Date of De		147	3 Time of Death
	Physicia		BETTY		THR	ASHER		Month	20	2009	1185A
g.	/Medic Examin		4a. Facility Name (If not institution, give	ve street and number)			r Location of Deat	h	4c. Coun	ty of Death	10 15
<i>*</i>		•	Collingswood	Nursing Home			Rockville			Montgon	ery
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th av. Year)	9. Birthpl Count	ace (State or Foreign
	Director		381-18-1235	1 □ M 2 🗷 F	91	Yrs.			11,1917		hio
	pu ,		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town	or Location				10	Od. Inside City Limits
	aryla shov	<u>-</u>	,		oo. ony, rom		C :				1 ∐Yes 2 ⊠ No
	he M :8a-f otifie	Director	Maryland Montgo	mery		10f. Zip Code	ver Spring	5	10g. Citizen of	Mhat Coun	trv2
	with t		10e. Street and Number	D 1		Tot. Zip code	20903	1	rog. Onzen o	U.S.	
	sath v	era	10401 Sweetbriar	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H		Specify Yes or No	14. Ra	ace - America	
92	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	CI III 0.0.	If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	an, Mexican, Puer Specify:	to Rican, etc.)	BI Spec	ack, White, e	
5-003	ural"	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	160	Decedent's Usual Occup	action		16h Kind of	Business/Inc	White
7	"nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give kind of work done life. DO NOT use retired	during most of wo	rking	16b. Kind of	Dusiness/inc	lustry
2121	withir	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+) 2		Homemak				Own Ho	ome
	filled Hygid ther snt, th	ပ္ပိ	17. Father's Name (First, Middle, Las.					me (First, Middle	l , Maiden Surna	ame)	
au	be eve	Be c	Gordon Alva					Letiti	a Stevens	5	
2	should be filed and Mental Hygi s marked other numatic event, ti	ဥ	19a. Informant's Name/Relationship		19b	. Mailing Address (Street	and Number or R				Code)
Maryland	nd 2 salth an 27 is rrtrau		Gerald R. Thrasher,	·		0401 Sweetbrian					ŕ
	1 a He em	,	20a. Method of Disposition	DI MODEINO	20b. Place of	Disposition (Name of	i	Date	20c. Location		
altimore,	0 0		1 Burial 2 ACremation 3			ry, crematory or other place	0.01	29/2009	Rrontw	ood, Ma	rvland
	iit. Partme	9	4 □ Donation 5 □ Other (Special Signature of Figure 1) Other (Special Service Lice		FORE LI	ncoln Cremator 22. Name and Addre	J ; ·	2372003	Diene	700u, 12	il y land
Ba	permit. Pag Department Important: I any injury o		Shi			Hines-Rinald 11800 New Ha	li Funeral	Home, Inc	ver Sprii	ng. Mary	vland 20904
			23a. Part. Enter the disease, or con shock, or heart failure. List only	nplications that caused th	ne death. Do r						Approximate
			shock, or heart failure. List only Immediate Cause (Final	y'one cause on each line.		·					Interval Between Onset and Death
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	nsit nsit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events							-	
	execu n and al-tra	Xa	resulting in death) Last	C Due to (or as a o	consequence	of):					
8760,	icate be executed physician and s the burial-transit			► d							
289		edical		- U.							
X	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf		-5-			23d. [Date of delive	ery
P.O. Box	death atte	cia	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y 		1	Month	Day Year
o	the o	Jysi	9 ☐ Unknown	9∐Unknown							
	w requires that the deben signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting ir	n the underlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
5 S	quires n sign	d by						1 🗆	Yes 2 No	3 🗌 Prob	ably 4 Unknown
Records,	w red	Completed						24a. Was		o. Were auto	psy findings available
æ	he lav e has age 2	шć						perf	ormed?	death?	mpletion of cause of 2 ☐ No
	sician: The certificate harector, page		25. Was case referred to medical				26 Place of De	eath (Check only	2 🔀 No	1 🗆 Yes	2 NO
>	s cert	o Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	= 2	itpatient 3 DOA Oth	or:	Home 5□Res		ther (Specif	iv)
Division or Vital	Attending Physician: r death. ector: After this certifics by the funeral director, p): To	27. Manner of Death	28a. Date of Injury	28b. 1	Time of 28c. Inju			how injury occ		
0	ndlng I th. :: After e funer	ıţi	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	rear)		rk?]Yes 2 □ No				
<u> S</u>	or Attendafter death Director: in by the	ertification:	3 Suicide 6 Could not l 4 Homicide determined	20e. Flace Of Higury	/ - At home, fa	ırm, street, factory, office		28f. Location	(Street and Nu	mber or Rura	al Route Number,
á	al or after al Dire	ert	4 [] Hornicide	building, etc.	(Specify)			City of 10	iwn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	alC		hysician: To the best of							
	n 24 l	Medical	(Check only 2 ☐ Medical Exa	aminer: On the basis of e and manner state		id/or investigation, in my	opinion, death occ	curred at the time	e, date and plac	e, and due to	o tne cause(s)
	To the within To the company	Ž	29b. Signature and title of certifier		h.	29c. Licens			29d. Date sig	ned (Month,	Day, Year)
	_		Marine	Holder	neel	D25	5348		6/2	309	
,	10		30. Name and address of person who							,	
_			Marcia Goldmark, M				00, Rockvi	lle, Mary	Land		
	Sta	ite	31. Date filed (Month, Day, Year)	9 Pendu	's Signature	1.48					
	Regist	ar	JUN 23 200	19 Buch	D. 14	Tarke.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Year Day nomas 2009 06 4c. County of Death 4b. City, Town, or Location of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 36 car /Medical 4a. Facility Name (If not institution, give street and number) Examiner veritis' MON HOSPIYA akoma CAT 5. Social Security Number Under 1 Year | If Under 24 Hrs. | 9. Bifthplace (State or Foreign 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 ₹ M 2 □ F 54 577-98-8508 JUNE 30 1954 TRINIDAD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mactical Examiner must be notified at 1X Yes 2 □ No Director MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 20783 USA 8506 14th PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify BLACK Specify: ğ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) AUTO BODY MECHANIC PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS LAWRENCE OLLIVERRIE MELVINA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWRENCE OLLIVERRIE/BROTHER of Health 6721 SAND CHERRY WAY CLINTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Date permit. Pages Department of Important: If it any injury or or 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/30/2009 SILVER SPRING, MARYLAND GATE OF HEAVEN 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 19510 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pus to for as a consequence of: Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) burial Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 □Yes 2 □ No Ö 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by sign 1 be 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has lirector, page 2 s 2 00 2 No 1 ∐Yes 1 ☐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide **Legisting Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Date filed (Month State **JUN 2 5** Registrar

YLES, MD Leashing

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year OSEPIH VUKOVICH 10:45AM JUNE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY MONTGOMERY HOSPITAL GENERAL DLNEY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Chio 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1**X** M 2□ F April 4, 71 1938 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 14204 Castaway Drive 20853 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ∐Yes 2. No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tax Attorney I.R.S. 17. Father's Name (First, Middle, Last)
Joseph M. Vukovich 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Donchatz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Ann Vukovich/Wife 14204 Castaway Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Method of Dispussion

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

**Concert(Page(fy)) ent Continuent June 26, Gate of Heaven Cemetery 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. CRU 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter 1 e diseas. In complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONI disease or condition resulting in death) 48HRS Due to (or as a consequence of): LEMIELINATING POLYNEUROPATHY HRONIC INFLAMMATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. if yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ TENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Certification: To

Physician /Medical Examiner

Funeral

Director

28a-f show

with

within 72 hours after death

Baltimore, Maryland 21215-0036

ir than "natural", or items 23a or 28a-f shov

Il Hygiene.

Is marked other

Health and Mental

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra

and burial-tran SE for

law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

attending physician ģ signed

 Hospital or Attending Physician: The lage hours after death.
 Funeral Director: After this confliction to be a few forms. within 2 To the

AULIE KENAL PAILURG										24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
HYPE	ERKALE	EMI	. 1							Ì	performed? 1 ☐ Yes 2 ☑ No	death?	2 N O		
25. Was case refer examiner?	red to medical	26. Place of Death								th (C	(Check only one)				
1 Yes 2 □	No	Hospita	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										y)		
27. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	1	a. Date of Injury (Month, Day, Ye		28b. Time of Injury	М		Injury at Work? 1 ∐Yes	2 🗆 No	28d	I. Describe how injury	jury occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	niner: C	: To the best of m On the basis of exa nd manner stated.	aminati	vledge, death of investigation and/or investigation	occurre	ed at t	the time, d my opinio	ate and place n, death occu	e, and	d due to the cause(s) at the time, date and	and manner as s place, and due to	tated. the cause(s)		

29b. Signature and title of certifier ASCURINUZ, MD 29c. License number D0059418 29d. Date signed (Month, Day, Year) JUNE 22, 2009

ULUYEMISI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 PRINCE PHILIP DR., OLNEY, MD 20832 PLINEMIS! ADEWUNMI, MD MONTGOMERY GENERAL HOSPITAL

State Registrar

cal

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# Flack Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death JUNE 22,2009 Physician SHERWOOD 11:22 P M JAMES WARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12503 MACDUFF DRIVE FT. WASHINGTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 12 M 2□ F Months Days Hours Min. 228-70-9036 MAY 20,1949 Director 60 VIRGÍNIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Director MD PRINCE GEORGES FT. WASHINGTON the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12503 MACDUFF DRIVE 20744 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

The marked other than "natural", or tiems 23 ant. If item 27 is marked other than "natural", or tiems 23 any or other traumatic event, the Medical Experiment mast Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. SECRET SERVICE Elementary/Secondary (0-12) 12th College (1-4or 5+) OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** WARD **EMMA** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12503 Macduff Dr. Fort Washington, Maryland 20744
50711 OAK COURT INDIAN HEAD, MARYLAND 20640 V'Etta C. Ward/Wife OAK COURT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LEVEL BAPTIST 06-27-2009 BEDFORD COUNTY, VIRGINIA 4 Donation 5 Dother (Specify) gnatury of Funeral Service Lo 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LLC 3005 12th STREET N.E. WASHINGTON, DC 20017 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENAL CANCER 1.5 yrs. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Division of Vital 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2⊠No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00068056 10

State Registrar

31. Date filed (Month, Day, Year)

Name/and address of person who comp

ELIZABETH K. PFAFFENKOTH, M.D.

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

JUN 2 4 2009

Beneva S. Jane

1221 MERCANTILE LANE LARGO, MARYLAND 20774 3rd FL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,25 per me, g892,07/21/09dhb
Reg. No.
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 2137 Regina Dolanna Wallace 06 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner VICOMICO 4HI ASLIVA 8. Date of Birth (Month, Day, Ye 11/5/1921 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2/CXF 214-14-4610 MD 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director MD Ocean Pines Worcester with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 174 Windjammer Rd. USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 🔀 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Specify: white 3 X Widowed 4 □ Divorced the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker nt of Health and Mental Hygin If Item 27 is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Szczech Edgar C. Gretsky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 S. Main St., Berlin, MD 21811 Melvin Wallace / son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 6/30/09 Baltimore, MD 4 □ Donation 5 □ Other (Specify) of Funeral Service Li 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician henston (Spontaneous) retroper tones disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner on, The law requires that the death certificate be executed Treatment for Atrial Fibrillation physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?

1 Yes 2 Ho 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number D62995

Registrar

State

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carrol street Salisbury MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

utcheon MD

32. Registrar's Signature

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31. Date filed (Month, Day,

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(First, Middle					2. Date of De Month	Day	Year 2009	3. Time of Death 9:00 a M	
not institution	Kan Hua Young	5	4b. City, Town	, or Location of Deati	June	21 4c. Cou	nty of Death		
burban H			,	Bethesda			Mont	gomery	
umber	1	e (In yrs. last birthd	Months Day			th ay, Year) 8, 1936		place (State or Foreign ntry) aiwan	
Decedent 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits	
Mont	gomery			Potomac				1 ☐ Yes 2 😿 No	
nber			10f. Zip Cod	9		10g. Citizen	of What Cour	ntry?	
1 Pipest	em Place			20854			U.S.A.		
ed 2 🗷 Marr 4 🗆 Divorced	12. Was Decedent E Armed Forces? ied 1 □Yes 2 ▼ N If Yes, Give Year or Dates:	Ever in U.S.	If Yes, specify Cuban, Mexican,			14. F E Spe	Race - American Indian, Ilack, White, etc. Cify: Asian		
15. Deceden	t's Education st grade completed)	I (G	ecedent's Usual Oc live kind of work do	rk done during most of working			16b. Kind of Business/Industry		
ndary (0-12)	College (1-4or 5	i+)	fe. DO NOT use ret Economist	Researcher		U.S. Government			
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(Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Addi					ural Route Numb	oer, City or To	wn, State, Zij	o Code)	
Young -	Spouse	P.(0. Box 1028	6, Rockville					
oosition Cremation 5 Cother (S	3 ☐ Removal from State pecify)	cemetery,	isposition (Name of crematory or other p	place)	Date 27/2009		on - City or To		
neral Service	. La can	tie	11800 New	aldi Funeral Hampshire A	venue, Si	<u>lver Spr</u>	ing, Ma		
he lisease, or rt failure. List (Final n	complications that caused only one cause on each line. Aspira	the death. Do not ne.		dying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death	
		a consequence of):						•	
Sequentially list conditions, if any, leading to intringulate cause. Enter Underlying Cause, (Disease or injury)									
rlying injury									
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t pregnant months?]No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		23d.	Date of delive	very Day Year				
ficant condition	ons contributing to death b		23e. Did tobacco use contribute to the cause of the caus						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration Urinary Tract Infection 24a. Was an autopsy performe 1 Yes 2 Ental death 3 Ectopic pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									
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No		ent 2 ☐ ER/Outp	atient 3 DOA		Home 5 ☐ Res			ify)	
h 5 🗖 Pendir investi	gation	ury 28b. Tin ay, Year) Inju		njury at Vork? I □ Yes 2 □ No	28d. Describe	how injury oc	curred		
6 □ Could detern	inna 28e, Place of Inf	jury - At home, farm c. (Specify)	, street, factory, offi	ce	28f. Location City or To	(Street and No own, State)	umber or Ru	ral Route Number,	
1⊠ Certifyii 2□ Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/	death occurred at the or investigation, in r	e time, date and plac ny opinion, death occ	ce, and due to the curred at the time	e cause(s) an e, date and pla	d manner as ice, and due	stated. to the cause(s)	
title of certifie			29c. Lic	ense number		29d. Date si	gned (Month	, Day, Year)	
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cn ith, l	Woodwa Day, Year)	Woodward, M.D., 5530	Woodward, M.D., 5530 Wisconsin	Day, Year) 2. Registrar's Signature	of person who completed cause of death (Item 23a) (Type, Print) Woodward, M.D., 5530 Wisconsin Avenue, #550, Chevy Cha	of person who completed cause of death (Item 23a) (Type, Print) Woodward, M.D., 5530 Wisconsin Avenue, #550, Chevy Chase, Mary1	of person who completed cause of death (Item 23a) (Type, Print) Woodward, M.D., 5530 Wisconsin Avenue, #550, Chevy Chase, Maryland 2081	of person who completed cause of death (Item 23a) (Type, Print) Woodward, M.D., 5530 Wisconsin Avenue, #550, Chevy Chase, Maryland 20815	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month DRANCH 2009 1015 4c. County of Deeth 4b. City, Town, or Location of Deeth BATTIMORE EYWORTA APT 212 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | Month, Dey, Year | 9,1955 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Yrs. 10b. County 10c. City, Town or Location BATTIMORE

Physician ACKIE 8.30 PM /Medical 4a Facility Name (If not institution, give street end number) Examiner Birthplace (State or Foreign Country) 5. Social Security Number Funeral 223-86-6774 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heatith end Mental Hygiene. Interest of them 27 is merked other than "natural", or items 23a or 28a-f show 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples must be notified at 1 No 2 No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number APT U.S.A. 2702 EJWORTH 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 KINo Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) (EDICAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 66 Wear 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 196 19e. Informant's Name/Relationship (Type, Print) TIMORE NO 21215 270 TRYWORKE AMES 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition metery, cremetory or other piece) Department of important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Life only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CINCLA **Examiner** Due to (or as e consequence of) Examiner The law requires that the death certificate be executed ettending physician end I for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): resulting in death) Last been signed by the e should be deteched t Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 IN 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funerel Director: After this certifics 28a. Date of Injury (Month, Day Year) Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Contifying Physician: To the best of my knowledge, death accurred at the time date and place, and due to the causals) and manner as stated. Medicai (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) Registrar

(ZV Ser)

0 9 2009

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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			For State Registrar	State o	f Marylan		artment (rtificate				giene /	200	9 2	1853
	· ·		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time	of Death
	Physicia /Medic		William Russell	Brown							7, 20		9:	15 P.M
	Examin	er	4a. Facility Name (If not institution,		mber)				ation of Death			ounty of Dea		
			Gilchrist Hospic 5. Social Security Number	e Care	7. Age (In yrs.	loot hirthdox	Tows		Under 24 Hrs.	8. Date of Bir	th	Baltin		te or Foreign
	Funeral Director		219-07-2464	1 XX M 2□ F	7. Age (III yrs.	92 Yrs.			lours Min.	(Month, Da	y, Year) 5, 19:	17 Ma	ountry) ryland	te or Foreign
			Usual Residence of Decedent			26.				Udil. Z	J/ 1J.	110		
	aryland show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							City Limits
	e Ma Ba-fs	Director	Maryland Balti	more.		Cock	eysvil							es 2.XXvo ———————————————————————————————————
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	ter de	Funeral	11. Marital Status 1 □ Never Married 2(X)Marrie	Armod Fo	orces?	45 - I			ınic Origin? (Sp Mexican, Puerto	Rican, etc.)	,	Black, Whi		,
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<u> </u>	l be fi ntal H ed ot ever	Be	17. Father's Name (First, Middle, L	ast)										
<u></u>	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A few 71 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the "nacical Examinal must be notified."	은	Thomas W. Brown 19a. Informant's Name/Relationshi	n (Type Print)		19h Mailir	na Address /S		<u>Nellie N</u> Number or Rur				Zip Code)	
Ĭ	C) 62		Mary Elizabeth E		fo)				n Road,					21030
v	s 1 and 2 f Health item 27 i		20a. Method of Disposition	PLOMII (MI			osition (Name matory or othe			Date 11,			r Town, State	
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=	permit. Pages 1 and Department of Health Important: If item 27 any injury or other th once.		21. Signature of Funeral Service L		1010				f Facility neral Ch			<u></u>	12 / 2011	<u>. </u>
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			Ba. Pari 1. Enter the disease, or o	om ations that only one cause on e	caused the deat	h. Do not en	ter the mode o	of dying, s	uch as cardiac	or respiratory a	arrest,		Approxi Interval	mate Between
F	hysician		Imm diate Cause (Final disease or condition	UPI	2 2 2 2	STROL	NTEST	7 NAL	- BLEE	DIM			DA	ind Death
and the	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):			- our					7
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	nsit	Examiner	Cause, Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	derice oi).								
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9	Attending Physician: The law requires that the death certificate be executed refeath. r death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	/ledi	IC CCMALC.											
5	leath certific attending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna birth 2 Feta		☐ Ectopic pre	gnancy			23	3d. Date of d Month	elivery Day	Year
,	at the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Preg 9 ☐ Unki	nant at time of one		Other (spec					WOTH	Day	Teal
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> :	ysician: nis certific director, I	To Be	examiner? 1 ☐ Yes 2 X No	Hospital:	Inpatient 2	l EB/Outpatie	nt 3□DOA	Othor	4 Nursing Ho			Other (S)	necify) #1	SPILE
5 7	aing Pn h. After thi funeral (27. Manner of Death	28a. Date		28b. Time o		: Injury at Work?		28d. Describe			, , , , , , , , , , , , , , , , , , ,	
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2	r Atterder de irecto	tific	3 Suicide 6 Could no 4 Homicide determin	ot be ned 28e. Place build	e of Injury - At he ing, etc. (Special	ome, farm, str	reet, factory, o	office		28f. Location City or To	(Street and wn, State)	Number or i	Rural Route	Number,
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	Hosp 24 hou Fune Itely fi	edical		Physician: To the xaminer: On the t	pasis of examina									use(s)
,	io the hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of certifier	and mar	nner stated.	_		_icense nu			29d. Date	signed (Mo.	nth, Day, Ye	ar)
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	-1		30. Name and address of pare if w	ho com lete 1 au	se of death (Item	n 23a) (Type	Print)	المال	1010		V - L	/ 0	,	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, DV

	1 - State Registrar				Ce	rtificat	te of L	Death		F	leg. No.	200	9	218	354
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			care Cente					imore				N/A			
al or	5. Social Security N 214–30–6.		6. Sex XX M 2□ F	7. Age (<i>In yrs.</i> 74	last birthday Yrs.	Months	f Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day Year)			9. Birthplace (State or Foreign County) Mary Land		
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le le	11. Marital Status	0.50	12. Was Dec Armed F	edent Ever in U	J.S. 13.	. Was Dece If Yes, spe	edent of Hi	ispanic Or ın, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)	1.	4. Race - A Black, W			
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To Be	17. Father's Name (First, Middle, Last) George V. Bowersox 18. Mother's Name (First, Middle, Maiden Surname) Helen Lorraine Crawford														
		19a. Informant's Name/Relationship (Type. Print) Mary A. Bowersox Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 3509 Hickory Avenue, Baltimore, Ma												,	21211
1	20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 □Removal from		Place of Disp cemetery, cre est La			al		/2009		ation - City		*	and
ouce.	21. Signature of Ru			11		Pane a Burge	nd Addres	ss of Facili	 eitz	Funera altimor	l Hor	me, I	nc.	21211	
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Sertifi	4 ☐ Homicide	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)										Number o	r Rural i	Route Num	ıber,
Medical Certification: To	29a. Certifier (Check only one)	iv Certifyi 2 Medical	ng Physician: To th I Examiner: On the and mai	e best of my kn basis of examin nner stated.	owledge, dea ation and/or i	ath occurred investigatio	d at the tir n, in my o	ne, date a pinion, de	and place, eath occur	and due to the red at the time,	cause(s) a	and manne place, and	r as sta due to t	ted. :he cause(s	5)
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	30. Name and addr	ress of person	who completed cau		m 23a) (Type	e, Print)	1)	۱۰ دسر	026		• 1	1 /			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Vrow ricia 2009 /Medical 3:38 AM July 1, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Arunde1
9. Birthplace (State or Foreign Country) Anne 8. Date of Birth (Month, Day, Oct 19, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under **Funeral** ^{Year)} 1928 Days Months Hours Min. 80 **Director** Massachusetts 027-24-0700 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at MD Anne Arundel Director Linthicum 1 ∐Yes 2√∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Sycamore Road Funeral 21090 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☐X If Yes, Give Year or Dates: or, 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify: white <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) homemaker own home and Mental Hygi Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Herber Wylie Greenhalgh Dorice Farmer or other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Barrows/spouse 205 Sycamore Road Linthicum, MD ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐ Other (Specify) nature of Funeral Section Ronal d 22. Name and Address of Facility Bai State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pa v 1. Enter the dise v e, or o mp loations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sh. ck, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acric Lyacelo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year 5 ☐ Other (specify) Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown arinnThs Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 □ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📑 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Medical 29a, Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and tipe of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUPE

N

82. Registrar's Signature

RROU

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 📝 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AM^M Joseph Anthony Bowers July 6, 2009 3:51 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1158 Linden Avenue Baltimore Halethorpe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 15, 19 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☑ M 2 ☐ F 46 Yrs. 213-92-5865 1963 Maryland **Director** Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shor Examiner must be notified at MD Baltimore 1 ☐ Yes 2 ☑ No Director Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1158 Linden Avenue 21227 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes ZX No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify Bowers Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 7 Is marked other than "natur traumatic event, its Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 delivery driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk Joseph ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Bowers/spouse permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once. 1158 Linden Avenue Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature | Emeral Service | OHI 10 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ector complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 Enter the disease or complications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) ASPHYXIA Physician /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 KNo 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Succe By Hayins

281. Location (Street and Number or rural - ute Number, City or Town, State) 1532111 En Aug. 1 Natural 5 ☐ Pending investigation July 6, 200 9 0 35/A M 1E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 □Yes 2 No 2 Accident 3 Suicide 4 ☐ Homicide 6 ☐ Could not be To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Trimble Hill CT Luthono; lle Registrar's Signat, 31. Date filed (Month. bay, Year) State

DHMH 17 Rev 1/2001

Registrar

51 Hrs

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a, peryerbal, G893 /79/09 IT.

Amend 25 Telephone Maryland Beneriment of Health and Montal Hygiene

			Amend State of Maryland / Depa			lental Hygi	ene					
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of L	Jeath	Reg	3. No. 2	3. Time of Death				
	Physici		HERTA	BOGNER		Month	Day Year 2, 2009 12:30 A M					
Mary St.	/Medid Examir		4a. Facility Name (If not institution, give street and number)		Location of Death	3011	4c. County of Death					
/			FOREST HILL HEALTH & REHAB CENTER		REST HILI		HARFOR					
	Funeral Director		5. Social Security Number 214-40-7354 6. Sex 1 □ M 2√√ F 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Jan 7, 1	9. Bir 934 Ge	rthplace (State or Foreign ountry) rmany				
	fand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits				
	Mary a-f sh	iot	MD Harford Fores	t Hill				1 □Yes 2□No				
	or 28	Director	10e. Street and Number	10f. Zip Code		100	. Citizen of What Co	ountry?				
	s 23a		414 Dellcrest Drive		21050		USA	*******				
5-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modfell Evanitational to invitible of	by Funeral	If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates:	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.				
2-0	72 hoi	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupa	ation	ing 16	16b. Kind of Business/Industry					
2	vithin ane.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired,)	'''g						
2	filed v Hygie ther t		12 0 man	ager	18 Mother's Name		rocery store aiden Surname)					
an	should be tind Mental marked o	To Be	Alois Maier		Anna Du	•	iden Gumame)					
Maryland 2121	s 1 and 2 should be filed if Health and Mental Hygi item 27 is marked other other traumatic event, II			ng Address <i>(Street a</i> NE 171 S								
Baltimore,	6 O		20a. Method of Disposition 1 Derial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spacify)									
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Ronald S. Wade, Director St	2. Name and Addres	my Board		altimore	Street				
	Physician /Medical		23a. Part 1 Enter the dise se of coople flors "at caused the death. Do not enter shock, or heart failure. First only one cause on each line. Immediate Carse (Final disease or condition resulting in death) a. Due to (or as a consequence of):		MD 2120 g, such as cardiac	1 or respiratory arres	t,	Approximate Interval Between Onset and Death				
	Examiner	er	Sequentially list conditions, if any leading the immediate									
•	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):									
58750,	ficate be executed physician and s the burial-transit	edical E	d									
XOR	attending for use a	Physician/Me		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		livery Day Year						
ras, r	quires that an signed t	þ	Part II. Other significant conditions contributing to death but not resulting in the ur RENAL FAILURE, HYPERTENSION		tobacco use contribute to the cause of death?							
vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed	ATRIAL FIBRILLATION			24a. Was an autopsy performe 1 □ Yes 2 €	prior to	utopsy findings available completion of cause of				
	cian: sertific setor,	Be	25. Was case referred to medical examiner?		26. Place of Death		100	2 2 110				
5	Physi this o	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28h. Time of		4 Nursing Ho		ce 6 □Other (Spe	ecify)				
	ding h. After funer	tion	Natural 5 ☐ Pending (Month, Day, Year) Injury	Work?	at ? ′es 2 □ No	28d. Describe how	injury occurred					
DIVISION	il or Atten after deat Director: d in by the	Certification:	2			28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,				
:	le Hospita 124 hours le Funeral pletely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and the basis of examination and/or invaried and manner stated.	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner a e and place, and due	s stated. e to the cause(s)				
	Veithir Comp	Me	29b. Signature and title of certifier	29c. License	number	29d	. Date signed (Mont	th, Day, Year)				
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	1069	U	VLY Z,	2009				
			STANLEY M. KMAN - 1308 BUSINESS CE	· ·	- EDGEV	WOOD, MD.	21040					
	Stat Registra	~	31. Date filed (Month, Day, Year) \$2, Registrar's Signature	,		و لابل	- LVTV					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Buddenbohn 3:00PM 00 09 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner Church valtimore rendallstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Sex 1 M 2 □ F Months Days Hours Min 216-20-4530 Yrs. Director -02 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits. 10a State 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expressional barnotting at 1 ☐ Yes 2 No Director MD allstown Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Church 21133 ISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Fes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify ģ Whit 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last) College (1-4or 5+) Maker Self Employ abinet 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Christian Anne Tochermann ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 303 Bartram Lane, Bast Hockessin, DE 19707 Kennard M. Budden bohn/ Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Mb Keview Cemelay 17-10-09 4 ☐ Donation 5 ☐ Other (Specify) Greene Auneral STVS. 22. Name and Address of acility Vaucann 21. Signature of Funeral Service Licensee Randellstown, Ms 8728 Liberty Rd or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the dises Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LECURPRENT CANCER LITRINX to TRACITIZA MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SQUAMOUS CELL CARCINOMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 □Yes 2 No of Vital 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28133 taunden

8

State Registrar 31. Date filed (Month, Day,

6569 N. CHARLES STHUS, SALTMORE MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 per MD 8893 7/9/09 TT
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Marylan		rtificate of			Reg. No?	009	21859	
1	Physici /Medic		1. Decedent's Name (First, Middle, Las $Florence$	Block				2. Date of Dead Month July	5 Day	2009 ^{Year}	3. Time of Death 7:00 AM M	
)	Examin	. 5	4a. Facility Name (If not institution, give 5016 Westport Rd				r Location of Death Vy Chase			ounty of Death Iontgom		
E _y	Funeral Director		173 12 7014	ex 7. Age (In yrs. M 2 XF 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl 12/06/	1922	Co	nplace (State or Foreign untry) sylvania	
036	ne Maryland 8a-f show ptified at	ector	Usual Residence of Decedent 10a. State 10b. County PA Lackawa		y, Town or Lo	Scra	nton		10 0"	10d. Inside City Limits 1 1 Yes 2 □ No		
	ath with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 1110 Quincy Ave.			10f. Zip Code	18510	Unit	g. Citizen of What Country? United States 14. Race - American Indian,			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No	Specify:	pecify Yes or No Rican, etc.)	S	White		
Maryland 21215-0036	d within 72 h giene. er than "natu the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired Secretary	during most of wor. d)			e Admi	nistration	
land	uld be file Mental Hy irked othe	To Be C	17. Father's Name (<i>First, Middle, Last</i>) James Rabki				18. Mother's Nam Sadie		Maiden S lin	'urname)		
, Mar,	and 2 sho ealth and f 27 Is ma er trauma		19a. Informant's Name/Relationship (Lester Block /	**		ng Address (Street Quincy A				City or Town, State, Zip Code) . 18510		
Baltimore,	Pages 1 annent of He ant: If item ury or oth		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	memoval from State		ace of Disposition (Name of metery, crematory or other place) $\begin{array}{c} \text{Date} \\ \text{July} & 8 \\ \text{ton Jewish Cemetery} \end{array}$				Dalton,		
Balt	permit. Departi Importi any Inj once.	8	21. Signature of Funeral Service Licer	maiss	_	2. Name and Addre Ziman Fun		~		son St PA 1	8510	
	Physician	110		Approximate Interval Between Onset and Death								
	/Medical Examiner		disease or condition resulting in death)	a. Metaster Due to (or as a conseq								
	cuted nd nd ransit .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
68760,	rificate be executed ig physician and as the burial-transit	/ledical Ex	resulting in death) Last	Due to (or as a conseq	o (or as a consequence of):							
P.O. Box 68	death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta	c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown					23d. Date of deliv		
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did t		_	o the cause of death?	
Il Records,	The ate h page	Completed							an 24b. Were autopsy findings available			
Vita	Physician: Th this certificate ral director, pac	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital:	150/Outratio	- 2000 Oth	26. Place of Dea			Daugh	ter's	
n or	Ing After	on: To	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju Wo		28d. Describe			cify/ Residence	
Division or Vital	Atten r deat ector: by the	Certification:	€ ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				Yes 2 □ No	28f. Location (City or To		t and Number or Rural Route Number, tate)		
	e Hospital or 124 hours afte e Funeral Dir letely filled in	Medical (nysician: To the best of my knowniner: On the basis of examination and manner stated.								
)	To the lewithin 24	Me	29b. Signature and title of certifier	MO		29c. Licens	OSSYS			signed (Mont	h, Day, Year)	
			30. Name and address of person who		m 23a) (Type,	Print) S Ra =	4415	Coneral	ler	10,2	1093	
	Sta Registi		31. Date filed (Month. Dav. Year)	32 Registrar's Sign	ature				5			
DH	MH 17 Pay 1/2	-0	JUL (1.8.50)	19 Getwa 1	1. 196	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AM BRENT AURA 3RD 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner HALL GERTATRIC BAHIHORE CENTER HIDDE PIVER If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 217-12-7675 1 ☐ M 2 88 MD Director 02.23.1921 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1. Yes 2 □ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6003 Hunt Ridge Rd. Unit 3531 21210 U.S Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othrany injury or other traumatic event æ Hugh W. Brent Helen V. Vogeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 19a. Informant's Name/Relationship (Type. Print) Raleigh Brent/Brother 6003 Hunt Ridge Rd. Unit 3531 Balto., 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐Removal from State 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P.A. Balto., MD 21286 Chesapeake Crem. 07.07.09 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate
Interval Between
Onset and Death
Un - Lineum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Demonte Immediate Cause (Final disease or condition resulting in death) ysician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

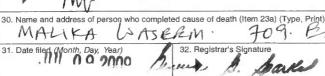
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Watural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

thin 24 hours at the Funeral I Hospital 0

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

29c. License number

D-38-7-54.

ASTERN BLVD - MD-2122

29d. Date signed (Month, Day, Year)

				partment of Health and Nertificate of Death	ntal Hygier Reg. 1	7007 71001		
	Physici		Decedent's Name (First, Middle, Last)	RENBAUM	2. Date of Death	Day Year 3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give street and number) COURTLAND GARDENS	4b. City, Town, or Location of Death PIKESVILLE		4c. County of Death BALTIMORE		
	Funeral Director		5. Social Security Number 215-07-9580 6. Sex 1 M 2 M F 7. Age (In yrs. last birthda 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, Yea 03/23/191	9. Birthplace (State or Foreign Country) MD		
	Aaryland f show	or	Usual Residence of Decedent			10d. Inside City Limits 1		
	sa or 28a-	I Director	10e. Street and Number 7920 SCOTTS LEVEL ROAD	10f. Zip Code 21208	10g.	Citizen of What Country?		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaridae must be indifficated or other traumatic event, the Medical Evaridae must be indifficated.	by Funeral		3. Was Decedent of Hispanic Origin? (Spirif Yes, specify Cuban, Mexican, Puerlo	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE		
Maryland 21215-0036	hin 72 hours a. "natural" Medicul Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) [Gas Decedent's Education (Gas Deceded Specific College (1,4or 54)] [Gas Decedent's Education (Gas Deceded Specific College (1,4or 54)]	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired)	king	. Kind of Business/Industry		
and 21	be filed winter Hygien od other the event, I'm	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	RETAIL SALES den Sumame) PETERSON		
Maryla	d 2 should th and Mer ?7 is marke traumatic	은		ailing Address (Street and Number or Ru 7101 SPATARO LANE		ty or Town, State, Zip Code)		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once.		20a Method of Disposition 20b, Place of Dis	position (Name of APT) or other place) URLAND 07/0	Date 20c. 8/2009 BA	Location - City or Town, State		
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility S 8900 REISTERSTOWN		N & BROS., INC. KESVILLE, MD 21208		
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death		
		Examiner	Sequentially list conditions, if any, leading to immediate caus. Enter U derlying Cause (Disease or injury that initiated events					
8760,	cate be executed physician and the burial-transit	dical	resulting in death) Last Due to (or as a consequence of): d.					
.O. Box 6	The law requires that the death certifics tle has been signed by the attending pt tage 2 should be detached for use as it	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year		
s, D	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Mknown		
Il Record	The law requested has been page 2 should	Completed	Cerebral Maley o	miclent -	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
n of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1	ient 3☐ DOA Other: 4 Jursing H	th (Check only one) ome 5 ☐ Residence 28d. Describe how in	e 6 ⊡Other (<i>Specify</i>) njury occurred		
Division of	nl or Attendir after death. I Director: Af d in by the fu	Certification:	1 Natural 5 Pending (Month, Day Year) Injur 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	t and Number or Rural Route Number, late)		
0	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	rred at the time, date	a(s) and manner as stated. and place, and due to the cause(s)					
1	To T COE	Medical	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type)	29c. License number	317 g	Date signed (Month, Day, Year) Noty 3 2009		
	Sta	te .	32. Date filed (Month, Day, Year) 22. Registrar's Signature	2434 WA	elude	re Cure felt, -		
	Registr	ar	JUL 0 9 2009 Sentes B. Ja	ules				

Bren baum,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

oseph wayne be	1	State of Maryland / Department of Health a - For State Certificate of Death Registrar	no iviental H		ı. No. 20	09 2186
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 1649 hrs
wedicai Examin		Joseph Wayne Berry 4a. Facility Name (if not institution, give street and number) 4b. City, Town,	or Location of Death	July 5, 200	9 4c. County of De	
		Harbor Hospital Center Baltimore		_	n/a	
Funeral Director		220-42-3770 1 M 2 F 03 Yrs.	ear If Under 24Hrs ays Hours Min	_		Birthplace (State or Foreign Country) [aryLand
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show 1 at once.	힐	MD Anne Arundel Linthicum				1 Yes 2 No
the N	Il Director	10e. Street and Number 561 Sarah Avenue 21090	0		g. Citizen of What C	
eath wi	Funeral	Never Married 2 A Married	Hispanic Origin? (Sp pan, Mexican, Puerto		14. Race - An White, etc	nerican Indian, Black, c.
after d	ð.	3 Widowed 4 Divorced If Yes, Give Year or Date:			Specify:	White
2 hours "natur	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occup during most of working life in the control of the control			16b. Kind of Busine	ss/Industry
1036 vithin 72 ene. er than '	Completed	11 0 Construction				ed Houses
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. Titem 27 is marked other than r traumatic event, the Medica		17. Father's Name (First, Middle, Last) Walter Berry	18.Mother's Name	e (First, Middle, M Irene E	,	
2121 ould be fi ! Mental !	P Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str				tate, Zip Code)
e, MD 1 and 2 short Health and 1 item 27 is r traumatic		Terry Berry / Wife 561 Sarah Av				
TOFE, ages I an nt of Hee tr. If ite other tr		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of a crematory or other place)		Date	20c. Location - City	
		4 Donation 5 Other Specify: Bayview Cremator 21. Signature of Funeral Service Licensee 22. Name and Addre		8/2009 ubbard F	Baltimor uneral Ho	e, Maryland
Balt permit. Depart Impor injury		Mill Bayland 4107 Will	kens Aveni	ue, Balt	imore, Ma	ryland 21229
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.				Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (morphine) and cocondition resulting in death) Due to (or as a consequence of):	caine into	oxicatio	<u>n</u>	Deali
	١	Sequentially list conditions, if any, leading to immediate				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
uted id ansit	ă	events resulting in death) Last Due to (or as a consequence of): d.				
ox 68760, sath certificate be executed attending physician and attending physician and or use as the burial - transition or use as the burial - transition.	Medical	XUNPENDED AMENDED 23a,27,28a-f,perME, g	3893 7/10	/09 TT		
3760, ificate be g physici s the buri	§ [IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregn	ancv	23d. Date of deli Month	very Day Year
Box 687: death certifice the attending per for use as the	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	4 Pregnant at time of death 5 Other (Specify)			20, 100.
O. Bc it the des	ᇍ	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	se given in Part I.	23e. Did tobacco use contribute to		e to the cause of death?
P.C.	d b			1 Yes	2 No 3 1	Probably 4 Vunknown
cords,	Completed			24a. Was a	sy prior	e autopsy findings available to completion of cause of
Reco The law icate has	ĕ			perfor Yes	med? deat 2 ✓ No 1	h? Yes 2 No
ital Rec	8	examiner? Hospital: 4 Investigat 2 of EB/Outhodiest 2 DOA	other		Residence 6 C	Other:
n of Vi	١٤	Tes 2 No	Injury at Work?		ow injury occurred	outer.
trendin teath stor: A	atio	Natural 5 Pending Fd 7/5/09 Fd 3:50 pm	Yes 2 X No	unk		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 6 X Could not be determined (Specific) Suicide 6 X Could not be	e building, etc.	28f. Location (Sor Town, Sor Brookly	tate) 3905 8	r Rural Route Number, City th St,
To the Hospita within 24 hours To the Funeral completely fille		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time,		d due to the cause	e(s) and manner as	
To the Hos within 24 h	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opin and manner stated.	at the time, date a			
	2	M . ST	ense number C.M.E.		July 6, 2009	(Month, Day,Year)
	ŀ	30. Name and address of person who completed cause of death (Item 23a)				-
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltir	more, MD 2120	11		
Sta Registr		31. Date filed (Month, Day, Year) 33 Registrar's Signature 34. January B. January				

1-

State Registrar		Cei	rtificate of l	Death		Re	g. No. 2 🛛 🗍	9 2 86
Decedent's Name (First, Middle, Las James W.	,					Date of Death Month uly	Day Yes 4 2009	3. Time of Death 3. 40 P M
Facility Name (If not institution, give 622 N. Woodw			4b. City, Town, or Esse		_	•	4c. County of D	
0.50 ocial Security Number 6. Security Number 11	ex 7. Age (In yrs. Ia	,	If Under 1 Year Months Days	If Under 24 F Hours M	lin. D	Date of Birth (Month, Day, CC 24	Year) 1920	Birthplace (State or Foreign Country) NJ
al Residence of Decedent								
State 10b. County Baltim		; Town or Lo E	ssex					10d. Inside City Limits 1 ☐ Yes 2X No
Street and Number 622 N . Woo	dward Drive		10f. Zip Code 2122	21		10	g. Citizen of What USA	Country?
Marital Status □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1X Yes 2 □ No	3. 13.	L Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specifuerto Ric	y Yes or No- an, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 XXNo dent's Usual Occup	Specify:		1.0	Specify:	White
15. Decedent's Edi (Specify only highest grade ementary/Secondary (0-12)	college (1-4or 5+)	(Give life.	kind of work done of the NOT use retired ter Mech	during most of v	working	"	6b. Kind of Busine Beth	•
12th Father's Name (First, Middle, Last) James Hicke	V					irst, Middle, Mi eader	aiden Surname)	
Informant's Name/Relationship (7		19h Mailir	ng Address (Street				City or Town. Stat	e. Zin Code)
Doug Caraway	,		3 Bauerr					nore MD
Method of Disposition	20b. PI	ace of Dispo	sition (Name of matory or other place		Date		Oc. Location - City	
1 □ & Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other <i>(Specify</i>	Removarirom State Oa	ik Lav	wn Cemet	7	/8/	n a	Baltimo	ore MD
4 Donalion 3 Done (Specify	7			ery /	/ 0 /	09	Darcinc	JI G IAD
Signature of Funeral Service Licen	<u> </u>	22	2. Name and Addre	-1				
	<u> </u>	22	2. Name and Addres	ss of Facility	300	Mace	Ave. Ba	alto. MD
Signature of Funeral Service Licego	see Lung blications that cause ye death		2. Name and Addres	ss of Facility Ly Fu	300 ner	Mace al Hom	Ave. Ba	alto. MD ssex 21221
Signature of Funeral Service Licego Part 1. Enter the disease, or comp shock, or heart failure. List only conditionally and the pediate Cause (Final	see Lung blications that cause ye death		2. Name and Addres	ss of Facility Ly Fu	300 ner	Mace al Hom	Ave. Ba	alto. MD ssex 21221
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Part I. Enter the disease, or comp shock, or heart failure. List only chediate Cause (Final ase or condition alting in death) uentially list conditions, y, leading to immediate be the disease or injury initiated events (Disease or injury initiated events (Disease or injury in the past 12 months? I Yes 2 No 9 Unknown II. Other significant conditions conditions or conditions or conditions or conditions or conditions or conditions or conditions or conditions.	b. Due to (or as a consequence)	ence of): ence of): ence of): fixed ath 3 [fixed the seath 5 [fix	2. Name and Address Connel er the mode of dyin Ectopic pregnanc Other (specify)	ss of Facility Lly Ful g, such as card y an in Part I.	300 ner	Mace al Hom espiratory arres 23e. Did toba 1	Ave. Bane of Esst. 23d. Date of Month acco use contributes 2 No 3 24b. Were prior deat deat No 1 1	Alto. MD Ssex 21221 Approximate Interval Between Onset and Death Day Year e to the cause of death? Probably 4 Unknow e autopsy findings available to completion of cause of 1? e 2 No
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State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Year)

1 - For State Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2009

Be Completed by Funeral Director

မ

Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral Director

Please	Type or Print				-	_	
For State Registrar		ryland / Depa Ce	rtificate of			ene 1. No. 2 0 0 9	21861
1. Decedent's Name (First, Middle, Las					Date of Death Month	Day Year	3. Time of Death
Mary Charlotte	Craig				July 7		3:05 P M
a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	
Holly Hill Manor		(1 t t t t t t t-	If Under 1 Year	If Under 24 Hrs.	0 0-4		imore place (State or Foreign
5. Social Security Number 212-01-2322 Jsual Residence of Decedent	M 2CLF	(In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) Jan. 29	(ear) Cour	olace (State or Foreign htry)
10a. State 10b. County Baltimo		10c. City, Town or Lo				1	0d. Inside City Limits
10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cour	ntry?
531 Stevenson I				1204	:6-V N	USA	an Indian
11. Marital Status 1 Mever Married 2 Married Married 2 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		was Decedent of F If Yes, specify Cub. 1 □ Yes 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify: W	
15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ina	ND Society	
12	n/a		ce Manag	er		Crippled Cl	
17. Father's Name (First, Middle, Last) Harry C. Craig					e (First, Middle, Ma lawthorne	,	
19a. Informant's Name/Relationship (Tune Print)	19h Maili	na Address (Straet	and Number or Rus	ral Route Number I	City or Town, State, Zip	Code)
Ronald L. Hooppe		11 A	Aucuba C	ircle, Or	mond Bea	ach, FL 32	174
20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			osition <i>(Name of</i> matory or other plan Cremator	ce)		Oc. Location - City or To Glen Burnic	
23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c.	consequence of):	ter the mode of dyi		or respiratory arres	um, MD 21	Approximate Interval Between Onset and Death 20 years
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 2 4 Pregnant at 9 Unknown	Pi Fetal death 3 €	☐ Ectopic pregnand☐ Other (specify) _	cy		23d. Date of deliv Month	ery Day Year
Part II. Other significant conditions of	ontributing to death but	not resulting in the u	anderlying cause give	ven in Part I.	1 ☐ Yes 24a. Was an autopsy	prior to co	
					perform 1 □Yes 2	ed? death? □No 1 □ Yes	2 1 40
25. Was case referred to medical examiner?	Hospital:		- C41		th (Check only one,		
1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28a. Date of Injury (Month, Day)	Year) Injury	of 28c. Inju	4 La Nursing Ho	28d. Describe hov	eet and Number or Rur	
	nysician: To the best o niner: On the basis of and manner stat	examination and/or in					
29b. Signature and title of certifier	Acules		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
30. Name and address of person who Theodore Houk, I				Suite 30	1, Towso	on, MD 212	04

2. Registrar's Signature

For State	State of M	laryland / Dep <i>Ce</i>	artment of H ertificate of L	ealth and M Death		ene 200	9 21865
Registrar 1. Decedent's Name (First, A	Middle, Last)		Timoato of E		2. Date of Death)	3. Time of Death
Physician Joseph	Benedict	Cod	ld		June 30	Day Yea 2009	4:40 P M
TATIONAL CONTRACTOR CO	tution, give street and number		4b. City, Town, or			4c. County of De	
Oak Crest Ca				ville			imore
Funeral 5. Social Security Number	6. Sex 7. A 1. ▼ M 2 ☐ F	ge (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) (irthplace (State or Foreign Country)
Director 218-18-6480 Usual Residence of Deceder		93			Sept 20,	1915 N	Maryland
70		10c. City, Town or L	ocation				10d. Inside City Limits
Maryland B	altimore		Parkville				1 ☐ Yes 2 X No
Maryland B			10f. Zip Code		10	g. Citizen of What (Country?
a state of the sta	Blvd., unit		2123			UDA	
# Heer death with the result of the result	12. Was Decedent Armed Forces' Married 1 X Yes 2 □	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto l	Rican, etc.)	14. Hace - Ar Black, Wh	nerican Indian, nite, etc.
10a. State 10b. Co	If Yes Give		1 □Yes 2X No	Specify:		Specify:	White
Complete Com	edent's Education lighest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done d	ation		6b. Kind of Busines	ss/Industry
Elementary/Secondary (0-	12) College (1-4or	5+) life.	DO NOT use retired,)			
S 11	n/a	Assis	stant Tick	et Manage 18. Mother's Name		Baseba	11
17. Father's Name (First, Mid	W.	Codd		Elizabe		Cleary	
P William 19a. Informant's Name/Rela			ing Address (Street a				. Zio Code)
Catherine W.			•				le, MD 21034
20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place			Oc. Location - City	
2 05 2 = 5 1 M Burial 2 □ Cremate 4 □ Departion 5 □ Other	tion 3 □ Removal from State er <i>(Speçify)</i>		edral Ceme	i	/09	Baltimore	, Maryland
Decemit. Bades 1 and 2 should be filed within 12 hours after death with the Maryland 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 11e. Maryland 2) (Color		22. Name and Addres	s of Facility eral Home	of Dula	aney Vall	ey Inc.
bryaprw. C	ELATY se, or complications that cause		10 W. Pado				Approximate Interval Between
sh 🧀 or hi art failure.	List only one hause on each I	ine.					Interval Between Onset and Death
Physician Immediate Caus (Final disease or condition result in in or ath)		rosclerotic a consequence of):	Caralova	iscular L	Useasu		
Examiner	h						
Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as	a consequence of):					
real frame leading to immediate frame leading to	d events c.						ļ
Example The Third Hying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence or).					
edical	d						
Attending Physician and Attending Physician and Attending Physician and Attending Physician and Attending Physician and Physicia	23c. If yes, outcome		_			23d. Date of	delivery
Head the death of	4 ☐ Pregnant		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	'		Month	Day Year
the de tached the de de tached the de de de de de de de de de de de de de	9 ☐ Unknown						
Part II. Other significant cor	nditions contributing to death	•					to the cause of death?
should sh	Heart Disease,	[neu mon	ia, Meur	46	1 🗌 Ye	s 2 No 3□	Probably 4 Unknown
Completed Comple					24a. Was an autopsy	/ prior t	autopsy findings available o completion of cause of
COM Coertificate h. Com Com Coertificate h. Com Com Coertificate h. Com Com Coertificate h. Com Com Coertificate h. Com Coertificate h. Com Coertificate h. Com Coertificate h. Com Coertificate h. Com Coertificate h. Coerti					perform 1 □ Yes 2	led? death 1 □ Y	? es 2□No
25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death	Hospital:		Othe	26. Place of Death			
Yes 22No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj	ient 2 ER/Outpatie ury 28b. Time o	ent 3 DOA	Nursing Hor	me 5 ☐ Reside 28d. Describe ho	nce 6 Other (S	pecify)
The state of Death of	ending (Month, Divestigation	ay, Year) Injury		? /es 2 □ No			
27. Manner of Death a Director: After ced in by the funeral general control of the funeral ould not be 28e. Place of In	jury - At home, farm, st tc. (Specify)	treet, factory, office	2	28f. Location (Str City or Town		Rural Route Number,	
Certification in the state of t						,	
To the Hospital or Attendal Within 24 hours after death To the Funeral Director: Attending to the Funeral Director: Att	tifying Physician: To the besi lical Examiner: On the basis and manner s	of examination and/or i	ith occurred at the tim nvestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
29b. Signature and title of ce	rtifier ,		29c. License		29	d. Date signed (Mo	onth, Day, Year)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	./						475
1 Charalle	Sfar	CRIP	R1719	144		7-1-	09
30. Name and address of pe	0/11	dooth (Itam 22a) (Tuna	Drint\		acKvilla.	7-1- MO 218	09 34

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** onth (lian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 86 198-18-5533 Jan 25, Director 1923 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "My doal Evan in etc. ust be notified at once. Director MD 1 ☐ Yes 2√ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Windlass Drive 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 14. Race - American Indian 11. Marital Status 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced '43**-**45 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) management analyst Dept of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis G. Cavenas Bridget Gilroy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Henderson/daughter P.O. Box 471 Lockwood, CA 93932 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Se 22. Name and Address of Facility Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 , S 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Demante **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Hypertan Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical signed by the attendir d be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Henknown 1 ☐ Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 | Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the within 2

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

A

JUL 0 9 2009

29c. License number

QUTAW ST Ente 308 BALTIMORE MD

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ETITUL CLUSTER 10:23 PM 2009 JUL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GONGLIN HOIPLEAR Columbia HOWARD If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🔀 F Director 218-26-5172 9/9/1931 Maryland Usual Residence of Decedent if filed within 72 hours after death with the Maryland at Hygiene.

other than "naturel", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 Mallow Hill Road 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked eny Injury or other traumatic events. Charles Mueller Helen Slater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine M. Harris / Daughter 3022 Michigan Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 7/7/2009 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 22. Name and Address of Facility Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK **Physician** 24 HRS /Medical Due to (or as a consequence of): Examiner 72 lms COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Unversions Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physicien: The law requires that the death certificate be executed 72625 BNEZ ISCHEMIA Due to (or as a consequence of) Physician/Medical ending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩0 24a. Was an 1 Yes 2° NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Box 68760, P.O. Division of Vital Records,

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) 1111 0 9 2009

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 36974

29d. Date signed (Month, Day, Year)

JUL 4 , 2009

21544

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:48 PM Donald L. Day 2009 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) March17,1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 215-28-1183 79 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Evan from roust be notified Director MD Hampden 1 TYes 2 □ No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 9 407 West 28th Street 21211 USA Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1≿∏Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 72 hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 P. 1 ☐Yes 2 🕱 No Specify 2 White 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Bricklayer Construction marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental should be John Lawrence Day Gladys Marie Hare 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Department of Health a Important: If Item 27 is any Injury or other tra once. Health a 13101 Eastern Avenue Baltimore MD 21220 Lori Nauman /niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 tment of F Burial 2 Cremation 3 Removal from State Saters Church Cemetery 7/9/09 Lutherville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final metastatic **Physician** adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ~ 2 weeks tamponade Seque titally list concilions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the. attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a P.O. 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural
2 Accident Division 5 Pending nours after death.

neral Director: A

filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral Completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT-2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALARIA MD E. UNIVERSIT , BALTIMORE, MD 21218 201 PKW NEHA 32. Relistrar's Signature 31. Date filed (Month, Dav. Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Year **Physician** PM 4:30 Doss uchard 07 2009 OZ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Broadmead Cochungville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 6. Sex Year) Hours Months Days 1**☑**M 2□F 86 351-12-031 Mar 30, 1923 **Illinois** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2√☐ No Baltimore Cockeysville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 13801 York Road T366 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates: 144–48 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: white ģ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ psychiatrist <u>healthcare</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Doss Edith Whinham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine D. Morrow/daughter P.O. Box 1721 Bend Oregon 97709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 23a. Part L Enter the diseas, or corr pil-Mions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 🗗 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 2 172 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred

Physician /Medical Examiner attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Funeral

Director

ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the "Modeal Examinal must be notified at

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; if Item 27 is marked other this any Injury or other traumatic access

Baltimore, Maryland 21215-0036

Examiner Physician/Medical signed by the a ⋧ To the Hospital or Attending PhysIcian: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed Be Certification: To

27. Manner of Death 5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 38392 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

31. Date filed (Month, Day, Year) JUL 0 9 2009

Registrar's Sign

and manner stated.

State Registrar

Medical

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month 10:25 PM July 2009 Elizabeth, Elbeck 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University of Maryland Medical Center N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2**XX** 69 MARYLAND 29 1939 OCT. 220-36-4359 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2X No RANDALLSTOWN MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21133 8843 HARKATE WAY Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2/CXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. SpecifyBLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE STATE OF MARYLAND 12yrs 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARIE BANKINS BO LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harkate Way, Randallstown, Md., James E. Elbeck/Husband 21133 8843 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 07-14-09 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Free eral S 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic Anoxic Encephalopathy
Due to (or as a consequence of): Palmonary Sarcoid 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a some guence of) Due to (or as a consequence of) If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Be ပ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exprintent runs on ruffied at ance.

/Medical

Examiner burial-transit attending physician for use as the buria by Physician/Medical been signed by the should be detached Completed certificate has treetor, page 2 s funeral director, Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown
Part II. Other significant cond

	24a. Was an autopsy performed? 1 □ Yes 2 ☑
	26. Place of Death (Check only one)
al:	Othor

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Impatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) July, 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meghan Dubina. M.D.

22 South Greene Street, Baltimore, MD 21201

1972738805

State Registrar

Medical



			For State Registrar	State of I	Marylan		artment of I				giene Reg. No. 20	09	21871
			Decedent's Name (First, Middle	, Last)						Date of Dea			3. Time of Death
	ysicia		SARAH	EVERSLEY						Month	Day U.	Year 7009	810 PM
	ledic amin		4a. Facilify Name (If not institution		er)		4b. City, Town, o	or Locatio	on of Death	1019	4c. County	,	0 101
EX.	amun	er	· ·		/								E CO
Fun	oral		NORTHWEST HOS 5. Social Security Number		Age (In yrs.	last birthday)	RANDA If Under 1 Year	If Und	ler 24 Hrs. 8.	Date of Birth	1	TIMOR 9. Birthpla	ice (State or Foreign
Dire			437-86-7791	1□M 2⊠F	95	Yrs.	Months Days	Hour		(Month, Da)		GUYA	* '
		-	Usual Residence of Decedent						1 10	C1. 11	1717	GOIII	1411
yland	被		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					100	d. Inside City Limits
A-f sl	2	흥	MARYLAND N	/A		В	ALTIMORE						1 XYes 2 No
h the	2	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of W	Vhat Countr	y?
th will	t d		1327 W. LAY	FETTE AVEN	UE		2121	7			U.S.	Α.	
:1215-0036 within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show	E a	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Decedent of I	Hispanic	Origin? (Specif	y Yes or No-	14. Race	e - Americai k, White, etc	
after or it	Ē	린	1 Never Married 2 Marri				i⊡Yes 2√∑√No			idit, 010.)			
ours ral",	20	d b	3XXWidowed 4 ☐ Divorced	Year or Date	s:			0,000				BLAC	
72 h	Sica	Completed	15. Decedent (Specify only highes	s Education t grade completed)		(Give	dent's Usual Occu kind of work done	during m	nost of working		16b. Kind of Bu	ısiness/Indu	stry
ithin re.	W.W	E I	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT use retire	· .					
led v Hygie	윤	පි	12yrs 17. Father's Name (First, Middle, I	act)		ASSO.	MINISTE	т' —			ST. JO Maiden Surnam		М.Е.
anc be fi be ot	evel	m		,									
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or	natic	၉ -	CROMPTON HOUST			T 401 14 27					A HOUST		2.4.)
Mai 12 st th and 7 is n	traur		19a. Informant's Name/Relationsh				ng Address (Street				-	-	
e, e	ther	13-	Josephine Lambe	ert/Daughte			Laurel		Baltim		laryland		
intof it	9		XXBurial 2 ☐ Cremation		ate 200. C	emetery, crer	sition (Name of natory or other pla	ice)	Date	7	200. Location -	Oily of 10W	ii, otate
altimore, rmit. Pages 1 ar partment of Hea portant: If item	- Jury	-	4 □ Donation 5 □ Other (Sp		MT		CEMETER		: 07-18-	09	LANSDOW	NE, M	ARYLAND
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any Ir		21. Signature of Funeral Service L	licensee		W	Name and Addro ILLIAM C 206 W NO	BRO	WN COMM	UNITY	FUNERAL	HOME	P.A.
		\neg	23a. Part 1. Enter the disease, or	complications that cau	sed the death					espiratory ar	rest,	- 1	Approximate Interval Between
Physic	ian	. 1	shock, or heart failure. List of immediate Cause (Final	only one cause on each	n line.		1 1000	1	1			, ;	Onset and Death
/Medi	_	1	disease or condition resulting in death)	a. Due to (or	as a consequ	uence of):	DIGI V	1100					
Exami	ner			N.	min	owho	olc. Str	che					
		je	Se grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence ot):	7						
and wecuted	ransi	Examiner	Cause (Disease or injury that initiated events	c.									
8760, cate be executed onlysician and			resulting in death) Last	Due to (or	as a consequ	uence of):							
8760, icate be ex	the br	dical	,	d									
	ast	Ned -	IF FEMALE:	1									
SOX Iff ce	r use	au	23b. Was decedent pregnant	23c. If yes, outcom	me of pregna th 2 ☐ Feta		Ectopic pregnan	CV				te of deliver	•
//sion of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certificate has been signed by the attending scior: After this certificate has been signed by the attending in	ed to	by Physician/Me	in the past 12 months? 1 □Yes 2 🗷 No		nt at time of d		Other (specify)	-,			Mo	ntn L	Day Year
P. O at the	etach	ڄ	9 Unknown										
es th	pe de	2	Part II. Other significant conditio	ns contributing to deat	h but not rest	ulting in the u	nderlying cause gi	ven in Pa	ırt I.				e cause of death?
ord equir	onld	ed								1 🗆 Y	es 2□No	3☐ Proba	ibly 4 🗹 Unknown
ec.	2 sh	Completed	10							24a. Was a	an 24b. \	Were autops	sy findings available ipletion of cause of
The	page	팃								perfor	med? d	death? 1 □ Yes 2	
Vital Rediction: The law	ctor,		25. Was case referred to medical examiner?					26. Pla	ace of Death (C		ne)		
hysle	e d		1 Yes 2 No			ER/Outpatier	nt 3 □ DOA Oti	her: 4 🗆	Nursing Home	5 ☐ Resid	lence 6 🗖 Oth	er Pspecky)	MZ itospice
on of ding Phys	Inera	ë	 Manner of Death 1 Natural 5 Pending 	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time of Injury	Wo	ıry at rk?	280	l. Describe h	ow injury occurr	red	
SiO reath.	The ft	gi	2 Accident investign 3 Suicide 6 Could n	ation	7.0		M 1	Yes 2	□No				
Division of Vital Records, to Attending Physician: The law requires the after death. Director: After this certificate has been signe.	<u>م</u>	Certification: To	4 Homicide determi	28e. Place of	injury - At ho , etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f.	Location (S City or Tow	itreet and Numb n, State)	er or Rural	Route Number,
Dital ours a urs a	led			1					10				
Division To the Hospital or Attent within 24 hours after deatt To the Funeral Director:	completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medicai E	g Physician: To the be Examiner: On the basi and manner	is of examina	tion and/or in	n occurred at the t vestigation, in my	opinion,	e and place, and death occurred	at the time,	cause(s) and ma date and place, a	anner as sta and due to t	ited. the cause(s)
To the To the To the	duo	₹	29b. Signature and title of certifier	Λ Ω			29c. Licen	se numbe	er		29d. Date signed	d (Month, D	ay, Year)
	-		> Williah	& Burlin	n		H4	59	31		July	gth 7	009
		-	30. Name and address of person v	vho completed cause	of death (Item	n 23a) (Type.					2017	, ,	
			Debarg	ih I Bi	Rton	28	35 Sm	ite 1	Menue	Svite	200 B	altimo	ore MD
Re	Stat gistra	~	31. Date filed (Month 1997, Year)	2009 32.169	istrar's Signa	d.	ares						

DHMH 17 Rev 1/2001

09-05263 Glenn Faulk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		ate of Death	Reg. No. 2009 2187				
Physician/ ledical Examine	Decedent's Name (First, Middle,Last) Glenn	Faulk Mo	te of Death inth Day Year 1420 hrs				
	Facility Name (if not institution, give street and number) 1151 Carrollton Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt 1	Months Dave Hours Min	ate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD				
aryland 8a-f show any at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town N/A Balt 10e. Street and Number		10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country?				
th the Maryland 23a or 28a-f sho notified at once,		21217	USA				
after death winers", or items	3 Widowed 4 A Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican Yes 2X No specify: Decedent's Usual Occupation (Give kind of work december)	, etc.) White, etc. Specify: Black				
1036 within 72 hours ene. er than "natu Medical Exan	Elementary/Secondary (0-12) G E D College (1-4 or 5+) N/A	during most of working life. DO NOT use retired) Public Works	City of Baltimore				
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mertal Hygiene. Titem 27 is marked other than " Traumatic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) Arthur Faulk 18. Mother's Name (First, Middle, Maiden Surname) Lorraine Brown						
and 2 should teatth and Meren 27 is mar traumatic ev		b. Mailing Address (Street and Number or Rural F 1421 N. Bond Street E	Route Number, City or Town, State, Zip Code)				
Baltimore, MC permit. Pages I and 2 s Department of Health a Important: If iten 27 injury or other traum	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of cremation 3 Removal from State	of Disposition (Name of cemetery, ory or other place) ion Cemetery 7-11-2	e 20c. Location - City or Town, State				
Baltimore permit. Pages 1 Department of E Important: If i	21. Signature of Funeral Service Licenses Bloom D Williams	22. Name and Address of Facility March 1101 E. North Avenu	East F/H				
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.						
xaminer	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,						
ed nsit	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last						
cecuted 1 and - transit	0.	7,28a-f,perME, g893 7/3	ለበ/በዓ				
760, cate be exect physician an he burial - tr			23d. Date of delivery				
Box 687 e death certifine the attending ed for use as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death The past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	Month Day Year				
i, P.O. Be rres that the de- signed by the a t be detached it d by Phys	Chronic alcohol abuse	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown				
cords, law require has been si 2 should b			24a. Was an autopsy performed? ✓ Yes 2 No 1 ✓ Yes 2 No				
tal Rec cian: The certificate ector, page	25. Was case referred to medical examiner?	26.Place of Death (Check only o	ne)				
on of Vinding Physicath. The After this he funeral dirticath.	1 Yes 2 No 1 Inpatient 2 ER/O	utpatient 3 DOA Other; Nursing Hor Time of Injury 28c. Injury at Work? 28d. 2:10 pm	Describe how injury occurred				
Division o pital or Attending ours after ceath. Iteral Director: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined Homicide 128e. Place of Injury - At home, factorise house	arm, street, factory, office building, etc. 28f. l	cocation (Street and Number or Rural Route Number, City or Town, State) 1151 Carrollton Ave				
To the Hospital within 24 hours To the Funeral completely filled	o the cause(s) and manner as stated. ime, date and place, and due to the cause(s)						
To wit To com	29b. Signature and title of certifier Amelia Outhall. MI	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 5, 2009				
	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine	er 111 Penn Street, Baltimore, MD 2	1201				
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a. V. I					
DHMH 17 Rev 1/2001	OF	RIGINAL	001/5				

DHMH 17 Rev 1/2001 OCME 2006

09-0534	‡ 1	
Daniel III	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

d James F	1	State of Maryland /		te of Death	a Wichtan	Reg. I	No. 2 1	09 218
Physicia cal Exami	an/	edistrar Decedent's Name (First, Middle,Last) Ronald James		Fox	lr.	2. Date of Death Month Da July 7, 2009	ay Year	3. Time of Death 1358 hrs
Lai Exailii		ta. Facility Name (if not institution, give street and number)		4b. City, Town, o	Location of Dear		4c. County of Deat	
1		8049 Park Haven Road	(In yrs. last birtho	Dundalk day) If Under 1 Ye	ar If Linder 24H	rs. 8. Date of Birth (N	Baltimore Co	
Funeral Director		215-92-4805 NM 2 F	42	Yrs. Months Da			Fore	ign ountry) Maryland
any	1	Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town or					10d. Inside City Limits
Maryland 28a-f show any d at once.	5	Maryland Baltimore	Dur	rdalk			Oit of What Ca	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	افق	10e. Street and Number 8049 Park Haven Road		10f. Zip Code	222		Citizen of What Co USA	unity?
uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was Decedent of H	ispanic Origin? (Specify Yes or No-	14. Race - Ame	erican Indian, Black,
death v r item nust b	uneral		X No	If Yes, specify Cuba		to Rican, etc.)	White, etc.	
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comp	oleted) 16a D	1 Yes 2 X N		f work done 16	Specify: Wh	
2 hour "natu 1 Exan	eted	Elementary/Secondary (0-12) College (1-4 or 5-	dı	uring most of working lit				,
uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	m d	12 years 2 years	, F.	lex-0 Ink l			Printin	ng
uld be filed wi Mental Hygier marked other c event, the M		17. Father's Name (First, Middle, Last) Ronald James Fox Sn.				me (First, Middle, Mai	den Surname)	
Menta Menta marke c even	ш	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Str	eet and Number o	r Rural Route Numbe		
id 2 shoulth and in 27 is aumati		Patricia Fox Mother	67	724 Boston	Avenue,	Baltimore	., Maryland	
permit. Pages 1 and 2 should be filed within 72 hours an Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		20a. Method of Disposition 1	te Sacred	Disposition (Name of only or other place)	s Cem.	ℓy^{13} , $\bar{\ell}$	undalk, l	Maryland
permit. Departm Imports injury o		Signature of Funeral Service Linens		Connelly 17110 Solle	ss of Facility Funeral f Ers Point	Home Of Du t Road, Du	ndalk, P. A Indalk, Ma	4. ryland 21222
hysician Medical		23a. Part I. Enter the disease, or complications that caused railure. List only one cause on each line.						Approximate Interval Between Onset and Death
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		Sequentially list conditions, b						
	iner	if any, leading to immediate cause. Enter Underlying Cause c.	quence of):					
ed sit	Exan	(Disease or injury that initiated events resulting in death) Last	quence of):					
to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and ompletely filled in by the funeral director, page 2 should be detached for use as the burial - transit		X UNPENDED X AMENDED #1	as noted	1, 23a,2/,p	erME, g	394 8/5 . /09	TT	
cate be	Physician/Medical	IF FEMALE: 23c. If yes, outcom	ne of pregnancy		Estable pro-	annocy.	23d. Date of deliv	rery Day Year
death certificate attending p	cian	past 12 months? 4 Pregnant at	time of death 5		Ectopic pre	grianicy	World	Day Tour
the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown			nium in Port I	23e Did toh:	acco use contribute	to the cause of death?
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w requires t is been sign should be d	Completed					24a. Was an		autopsy findings available to completion of cause of
e law r e has b ge 2 sh	ldm					autopsy perform 11 ✓ Yes 2	ed? death	?
certificat ector, pay	မ င၀	25. Was case referred to medical	Salari I	26.Pla	ce of Death (Che			
hysician: this certif I director,	O B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie		utpatient 3 DOA			esidence 6 🗸 Ot	ther: Scene
pital or Attending Physician: The law required ours after death eral Director: After this certificate has been si filled in by the funeral director, page 2 should b	on: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Inju (Month, Day,Y)	ry 28b. 1	· · · · · _	njury at Work? Yes 2 No	28d. Describe ho	w injury occurred	
Attender death	catio	2 Accident Investigation 28e, Place of in	jury - At home, fa	arm, street, factory, offic		28f. Location (St	reet and Number or	Rural Route Number, City
ital or A ars after ral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, Sta	ete)	
E Hosp 24 hou Funer etely fi		29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, dea	ath occurred at the time	date and place,	and due to the cause	(s) and manner as s	stated.
To the Hosp within 24 hc To the Fun completely i	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	nination and/or ir		nse number		29d. Date signed (
	2	250. Signature and title of certifier				OCME	July 8, 2009	= -91 : -=-7
/		30. Name and address of person who completed cause of d	JR, M	1.1).				
√ √		Theodore M. King, Jr., MD. Assistant M	ledical Exam	iner 111 Penn	Street, Baltim	ore, MD 21201		
9	tate	31. Date filed (Month, Day, Yang 2010 32. Redistra	r's Signature	back	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c&22perFH, G895, 8/10/09, WS

State of Maryland / Department of Health and Mental Hygiene 2 1 5

Amend #1,perMD g894 8/12/09 TT

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) Floyd Whitlock 2. Date of Death 3. Time of Death - IEam Month Year Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bout NSa Hone enes 19 ochrava If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** USA 2□ F Days Hours Months 0-5 250-56-1208 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 1x Yes 2 □ No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA 1822 Federal Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No black Specify Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Whitlock Sr Mozelle Brown ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Thomas/brother 3635 Forest Hill Road Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 Burial 2 Cremation 3 ☐Removal from State Metro Crematory Inc. 08/10/09 Baltimore, Maryland 4 Donation 5 Mother (Specify) in 22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave. Baltimore, MD 21215 Baltimore, MD 21215 21. Signature of Funeral Selver Ronal d ce Licensee 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac of Immediate Cause (Final disease of condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and deedeched for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【 No 24a. Was an cate has l autopsy perform 2 X No 1∐ Yes or Attending Physician: after death. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I lospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 0 9 2009

and 21215-0036

altimore, Mar

Division or Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U U

			1 - For Stata Registrar	State of Marylar		rtificate of I			Reg. No.		tons 1 W 1 V	
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Dea Month		Year	3. Time of Death	
	Physici /Medic		Mary Fo	RREST				6	2 1	2009	145 P.M.	
П	Examin		4a. Facility Name (If not institution, give		١٥	4b. City, Town, or	Location of Death	-	4c. Co	unty of Death		
				100-1-110	ter	Balt		10)				
	Funeral Director		214-24-1117	9X 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		9. Birthpl Count Virg	ace (State or Foreign ry) ;inia	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			,	10	d. Inside City Limits	
	Mary	tor	MD	P	no Him	iore					1√∑Yes 2 □ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	try?	
	h with	al D	1000 NG.	Imor St			21217			USA		
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U	l.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14.	Race - America Black, White, e		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Exam har must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Į.	ecity: Bla		
2-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind	of Business/Ind	ustry	
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2	should and Men is marka sumatic	욘	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	ng Address (Street			r. City or To	wn. State. Zip	Code)	
	and 2 sealth ar n 27 is ier trau		Isabella Lee/fri			Park Hei						
Je,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of natory or other place	-	Date		ion - City or To		
Ë	Pages nent of int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕅 Other (Specify	Hemoval from State	cometery, crem	natory or ourer plac						
Baltimore,	permit. Page Department Important: If any Injury or once.		21. Signature of Euneral Service Licent Ronal of S		r ₁ 22	Name and Addres State Ana	ss of Facility tomy Boa:	rd 655 W	. Bal	timore	Street	
			23a, Party, Enter the disease or com	olications that caused the deal	th. Do not ent	Baltimore er the mode of dvin	, MD 211	or respiratory ar	rest.		Approximate	
			23a. Parkl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on chiline. Immediate Cause (Final disease or condition									
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a consec		ma						
	Examiner	Jer		•	(401100 01).							
			Sequentially list conditions, if any, leading to immediate cause. Entar Indertying. Due to (or as a consequence of):								-	
	cuted	Examiner	that initiated events	C								
Ó,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							
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<u> </u>			IF FEMALE:	00-16						-		
Вох	The law requires that the death certite has been signed by the attendinage 2 should be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta	ıl death 3 □	Ectopic pregnancy			23d	. Date of delive Month	ry Day Year	
o.	the a	ysic	1 ☐ Yes 2 ₽ No 9 ☐ Unknowл	4☐Pregnant at time of c 9☐Unknown	ieatn 5∟	Other (specify)						
٥.	that the ed by detac	/Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?	
gp	uires sign lid be		Lym	Ohoma				1 🗆 Y	es 2□N	lo 3 🗆 Proba	ably 4 Unknown	
Records,	w require been significant	Completed	0 1	Dansouli	- O1			24a. Was	an 2	4b. Were autop	sy findings available	
	The la e has age 2	шо		227000				autop	med?	prior to con death? 1 ☐ Yes	npletion of cause of	
Vital		Be C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o		1 192	20110	
	hysician: The law his certificate has b il director, page 2 s	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth		ome 5□Resid		Other (Specify)	
0	Attending Physician: or death. ector: After this certificity the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe h				
<u>S</u>	Attendir death. ctor: Af y the fur	atic	1 Natural 5 Pending 2 Accident investigation		,,		Yes 2 □ No					
Division of	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow		umber or Rurai	Route Number,	
	pital o		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno	wiedze death	occurred at the tim	ne, date and place	and due to the	Pause/s) and	d manner as st	ated	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exemone)	iner: On the basis of examina and manner stated.	ation and/or inv	vestigation, in my o	pinion, death occu	rred at the time,	date and pla	ice, and due to	the cause(s)	
	To t To tl	Σ	29b. Signature and title of certifier	how mit		29c. License				igned (Month, L	Day, Year)	
) your U	year (VI)		02	6748		4/2	6/09		
			30. Name and address of person who	completed cause of death (Iter	1 23a) (Type,	Print) - AL	LS M	BA	LTC	S MO	2011	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature de	ules						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 SUME /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** 201 DAUTIO V 5. Social Security Number unk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 8, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk Sev **Funeral** Months Days 1 X M 2 □ F 59 Director Usual Residence of Decedent with the Maryland unk 10b. County 10c. City, Town or Location Od Inside City Limits unk 28a-f show unk the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director unk 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number unk 5 23a USA death v Funeral 12. Was Decedent Ever in U. unk Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ,or 1 □Yes 2X No ģ Specify: black 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Ing. M. Once. College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be unk ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Hospital 301 St. Paul Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) in state 21. Sign ture State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or residratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2.2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

31. Date filed (Month, Day, Year!

05071

29b. Signature and title of certifier

301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

UD SISS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 5, 17, 18 per inf. G893 //24/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Edward H. Gold 03 2009 /Medical 4b. City, Town, or Location.

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If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

4/29/1914 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPINAL ALNES BATTEMORI SADNI 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** New York 1 DXM 2 □ F 95 081-01-8282 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene.
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1 DXYes 2 □ No
If Yes, Give
Year or Dates: 41 - 45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Cable 12 0 Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Henry Edward Gold Anna Marie Seifried 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 705 Melvin Avenue, Annapolis, MD 21410 Ronald R. Holden / P.R. permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 7/6/2009 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** UKGOM Respiratory /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy Renal performed Acute 1 ☐ Yes 2 ☐ No 1 □Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending ours after death.
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Registrar

JUL 0 9 2009

JOWA CZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2009 1215 pM ui STH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** ltimore Ba MOS nes If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days 1□ M 2 🕅 F Maryland 0 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces?

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(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. BOARD Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30062 19a. Informant's Name/Relationship (Type. Print) [COUSIN] 20b. Place of Disposition (Name of cemetery, crematory or other place) Marietta Georgia 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses W. North 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death 2-3 \$\delta^2\gamma S\$ Immediate Cause (Final wumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): LUKNOWN Examiner static Colon if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) o. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 No 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA oţ 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28h Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Wilatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** $a_{\,\text{M}}$ Julia I. Holley 2009 /Medical 2:20 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Belair Balto 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2√2 F Director 45 214-90-2059 10-22-1963 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Madical Examiner must be notified at MD Director 1 ☐ Yes 2 🔀 No Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1205 Magness Court 21017 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Harford County Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Substitute Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Alvin Fields, Sr traumatic ပ Marie Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra Keith Holley-Husband 1205 Magness Court Belcamp, MD 21017 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury U. M. Cem 7-7-2009 White Marsh, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility March East F/H 3 & mad 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final elemono **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Tulia Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate performe 2 1 □ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ∐Yes 201X No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or e Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number ပ DO 0 63220 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harnie 0 28,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 If Under 24 Hrs. NONTAWES 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** 7. Age (In. vrs. last birthday 1 M 2 □ F Months 213-14-5407 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan is a routified at once. BALTIMONE Director 1 ☐Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Osial Occupation (Give kind of work done during most of working life. DO NOT use retired)

DRIVER College (1-4or 5+) /Secondary (0-12) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relation ip (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 B Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ieral Director. After this certificate has been signed by the attending physician and 'filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Dav 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 6/28/09 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. RUJUPARSEMD 25 Main Sty Suite 200, Rejsterstown, 11 MD, 21136

Registrar DHMH 17 Rev 1/2001

State

N.S. Rujapaksemo 31. Date filed (Month, Day, Year)

JUL 0 9 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Harbor 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F Director 215-50-7844 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at MD Director

Certificate of Death Harmon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Months

2. Date of Death Month Year dune 09 4c. County of Death

4b. City, Town, or Location of Death

Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 2, 195 Days

Birthplace (State or Foreign Country)

10c. City, Town or Location

7. Age (In yrs. last birthday)

58

Maryland 1950 10d. Inside City Limits

Baltimore

1√ Yes 2 No

10e. Street and Number

917 1st Street

10f. Zip Code 21225

USA

10g. Citizen of What Country?

11. Marital Status 1 Never Married 2 Married

Funeral

ģ

Completed

Be (

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Examiner

Be Completed by Physician/Medical

Medical Certification: To

, or

"natural"

Pages 1 and 2 should be innent of Health and Mental

S

Department of Health ar Important: If item 27 is any Injury or other trau

Physician

Examiner

as the burial-trar

Hospital or Attending Physician: The law requires that the death certificate be executed

After

s after death

within 24 hours a

filled in by

P.O. Box 68760,

Division of Vital Records,

/Medical

Maryland 21215-0036

3altimore,

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No

14. Race - American Indian, Black, White, etc. Specify: black

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

automotive

17. Father's Name (First, Middle, Last)

Joseph C. Rzepkowski

18. Mother's Name (First, Middle, Maiden Surname) DeVonne Hollingshead

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Gary Harmon/spouse

917 1st Baltimore, MD 21225

20c. Location - City or Town, State

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in stat in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

car detailer

21. Signature of Euneral Service Licensee Ronal d S. Wader Birector State Anatomy Board 655 W. B Baltimore, MD 21201

23. Part I. Enter the disease, if complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Hypertensi	vea	ind	Oute
Due to (or as a consequence of):	7	Dic	PNIP

Due to (or as a consequence of):

Due to (or as a consequence of

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

acuse

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ebstructing

Ling Disease

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗌 No 3 Probably 4 Unknown

ECLLY (

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manne of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

29a. Certifier (Check only

1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 12729 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam)23a) (Type, Print)

Hospital:

2300 Gamson Blud Balto 21216 Abonsyimo

State Registrar 31. Date filed (Month, Day, Year) JUL 09 32 Registrar's Signature

Division of Vital Becords P.O. Box 68760

			State of Maryland / Dep			ne	21002
Cap in	Physici /Medio Examir	cai	1. Decedent's Name (First, Middle, Last) Louis Ferdingad Huber 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year	3. Time of Death
-04	Funeral Director		Howard County General Hospital 5. Social Security Number 215-30-1665 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 79 Yrs.	Columbia, MD If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 3/27/19)	Howard 9. Birth Cot 30	nplace (State or Foreign untry) MD
the Maryland 28a-f show		Director	10a. State 10b. County 10c. City, Town or L	icott City	100	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
51215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ent, the Medical Evaminer must be notified at	by Funeral	3822 Spring Meadow Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education 16a. Dece	21042 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	tes ican Indian, etc.
31212 put	e d d al	Be Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	Eldercare	
_	以前です	1	Judith L. Loving-daughter 1735	ing Address (Street and Number or Run Susquehannock Dr.	McLean,	VA 22101	· · · · · · · · · · · · · · · · · · ·
	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	matory or other place) ark Cemetery 7/ 2. Name and Address of Facility Ha	10/09 I		, MD mily F.H.Inc
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that of used the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	112 Old Columbia P		ott City,	Approximate Interval Between Onset and Death
66/60,	cate be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			-	
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Unknown		very Day Year		
cords, I	been signed	þ	Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.	1 ☐ Yes	2 No 3 Pro	the cause of death?
אוומו חפווא	certificate has ector, page 2	Be Completed	25. Was case referred to medical examiner?	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 7	prior to condeath?	opsy findings available ompletion of cause of
VISIOII OI	ir death. ector: After this of by the funeral dir	Certification: To	1 Yes 2 No	of 28c. Injury at Work? M 1 Yes 2 No	me 5 ☐ Residence 28d. Describe how in 28f. Location (Street	jury occurred and Number or Rui	
D Idiana	24 hours after 5 Funeral Director filled in	Medical Cert	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deat and manner stated.	th occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as	stated. to the cause(s)
, t	within To the	Me	29b. Signature and title of Certifier M. D.	29c. License number 0 00 6 3 6 5 3	29d. I	Date signed (Month	, Day, Year) 2009
	51		30. Name and address of person who completed cause of death (Item 23a) (Type, Shawn Evon's 5755 Cedor	Print) Lone Columbia	, MD 2	1044	
	Stat Registra	ar	Shawn Evan's 5755 Cedar 31. Date filed (Month, Day, Year) - 32. Registar's Signature JUL 09 2009 Linear B.	ball			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

4,

^{Day} 2009 Year

4c. County of Death

July

Physician
/Medical
Examiner

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Gilbert F. Hanssen

4a. Facility Name (If not institution, give street and number)

and the second		1553 Lister Roa	ad		Hale	thorpe			imore		
Funeral Director		213-14-1033	7. Age (<i>in yr</i> s. 51	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h y, Year) 958	9. Birthplace (State or Foreign Country) Maryland		
and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Modical Examinational tendinical	ŗ	MD Baltin		aleth					1 □Yes 2 X No		
the l	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?		
h with 23a o		1553 Lister Roa	ad		212	27		USA	Δ		
ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Rac	e - American Indian, ck, White, etc.		
36 safter	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 □Yes 2 X No			Specify			
hour hour	ed b	15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	usiness/Industry		
215	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	during most of wo d)	rking				
21. Signarial vitility of the state of the s	Son	12	0	Car	penter			Const			
D 美工 To be of 17. Father's Name (First, Middle, Last) 18. Moth								t, Middle, Maiden Surname)			
arylan should be and Mental s marked o umatic eve	၉	Arthur D. Hanss		405 14-35			Mae Bot		State Zin Code)		
Man d 2 st th and th and th and traum		19a. Informant's Name/Relationship (Type Anna Mae Hanssen		1	ng Address <i>(Street</i> Lister F			-			
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filled within 72 hours alt partment of Health and Mental Hygiene. portant: If Item 27 is marked other than "natural", or yinjury or other traumatic event, the Marical Every page.		20a. Method of Disposition			sition (Name of natory or other place	`	Date		City or Town, State		
Pages ent o nt; If I		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ark Cemet		/2009	Baltimo	re, Maryland		
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Ign turn of Funeral Service License			2. Name and Addre				Home, Inc.		
o 525 58		* YOUN	J						aryland 21229		
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line						Approximate Interval Between Onset and Death		
Physician		Immediate Cause (Final disease or condition resulting in death)	CONO	NAN	7 1	1/619	215	1 156	3 non		
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Duc to (or as a coneau	uente of):							
cuted od ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
O, e exe ian ar irial-ti		resulting in death) Last	Due to (or as a conseq	uence of):							
68760, tificate be ex g physician as the burial	dica	d	l								
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	/Me	iF FEMALE:	3c. If yes, outcome of pregna	ancy				and Do	to of dolivory		
Bo leath aften for u	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	Ideath 3	Ctopic pregnant Other (specify)				te of delivery onth Day Year		
by the achec	hysi	9 Unknown	9 Unknown								
Records, P.O. Box The law requires that the death cer ate has been signed by the attendin agge 2 should be detached for use	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			tribute to the cause of death?		
ord							1 🗆 \	Yes 2 No	3 ☐ Probably 4 ☐ Unknown		
of Vital Recorc Physician: The law requi this certificate has been s al director, page 2 should	Completed						24a. Was autop	osy	Were autopsy findings available prior to completion of cause of		
_ = # e							1 □Yes	rmed2 2 ⁴ No	death? 1 □ Yes 2 □ No		
Vital sician: T certifical irector, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:		oth		ath (Check onl o				
on of ding Phy h. After this funeral d	ř	27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time of	f 28c. Iniu	rv at	Home 5 Resident	now injury occur			
nding ath. S. Afte	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	M 1	rk?]Yes 2∐No					
Division of lor Attending Phy after death. Director: After this din by the funeral d	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (5	Street and Numb	per or Rural Route Number,		
Division of Vita Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director,			1								
e Hospital	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.								
To the Hos within 24 hd Completely	Med	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)		
		1 shus	w	1	01	96 40		7/6	105		
		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type,	Print)	~ .	112		A.		
		MARCS 10	sutil in	0	1147		HAND	VER	11		
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Lan.	Kel						
DHMH 17 Rev 1/2		JUL 0 9 2009	32. Registrar's Signa	1900							

3. Time of Death

9:00 A M

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Loretta Johnson June 9,2009 0150 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Surburban Hospital Bethesda Montgomery | Months | Days | Hours | Min. | Min. | March | 12,1934 | Washington | DC 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖳 F 75 Director 578-44-9881 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercising the neutition once. 1 ☑ Yes 2 ☐ No Director Maryland Prince George Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7901 Esther Drive 20745 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Johnson Lora Hall ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Johnson/Daughter 7901 Esther Drive, Oxon Hill, MD 20745 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State June 20,2009 Waldorf, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Heritage Cemetery 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Licen-1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 1 □ Yes 2 Kino funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2 Kano Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA to To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: loglog Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Buo, MD 2005 7124 619/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Truong Bao M.D. 8600 Old Georgetown Rd, Bethesda MD 20816 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 5, 2009 2:23 PM M Beulah A. Joy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | June 29, 1912 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 👿 F Maryland 97 213-01-4979 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show be notified at 1 ☐ Yes 2√ No MD Solomons Calvert 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 20688 USA 13325 Dowell Road items 23a Completed by Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No f Yes, Give 1 Never Married 2 Married 5 Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. 8 0 supply clerk shipyard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norris Tilden Hardesty Lilliam Bowen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3810 Carson Court Huntingtown, MD Betty Sealey/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) S. Wade Funeral Service Ronald 22. Name and Address of Facility 21. Signatur State Anatomy Board 6550 W. Baltimore Street Baltimore, MD 21201
caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1. Enter the disease, or complications the shock, wheart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Ves 22 No 1∐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospina Community and Within 24 hours after death.

To the Funeral Director. After this of maniately filled in by the funeral difference of t P 28a. Date of Injury (Month. Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation Injury 1 □ Natural 745 PM Wheelchair Pushed over Cirb, palint 1 ☐ Yes 2 No 04 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide At home, farm, street, factory, office 4 ☐ Homicide determined SCHOMENS, MD Living Funly - Hermitay 13325 DENERERO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 20678 d address of person who completed cause of death (Item 23a) (Type, Print) 100 HOSPITAL DRIVE, PRINCE FREDERICK A LETCHFORD, MD HARLENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 9 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:35 P^M 5,2009 Jordan Tony July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 5, 1955 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 54 214 62 7591 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, The Medical Examinat must be notified at 1 ☐Yes 2 ☐ No Director Baltimore MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1300 E. Lanvale St. 21213 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 →No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Specify: black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cafe cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matilda Burgess Charles B. Jordan ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21213 Florence Jordan (sister) 1633 N. Bond. Balto, Md. other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 🛣 Other (Specify) Mausol Memorial Pk.July 14,2009 Balto.Co.,Md. King Manature of Funeral Service Licensee Calvin B. Scruggs Funeral Home ·1412 E. Preston St. Balto, 21213 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nuerwhe **Physician** /Medical Due to (or as a consequence of): Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to to, as a consequence of, Fa or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 1540 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 □ No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 5 ☐ Pending investigation 1 □Yes 2√2 No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number City of Town, State)
Baltimore County North Point 3 ☐ Suicide determined 4 Homicide TVno/2 TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, Hospital the

n 24 hours a er death.

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bletely filled in by the fur within 24 hou To the Funel completely fil 0

> State Registrar

29b. Signature and itle of certifie

29c. License number

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

Leh

and manner stated

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2005 Judith Annie Johnson /Medical 4c. County of Death 4h City Town or Location of Deat 4a. Facility Name (If not institution, give street and number, Examiner n/a Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Security Numbe **Funeral** Months Days Hours 1□ M 2XF 3/27/1941 68 Virginia 216-72-2536 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fivefical Examinar must be notified at 1 □Yes 2 No Baltimore Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21227 846 5th Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: Specify: ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I a. M. any once. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker O 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Una Carpenter John Peak ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / Husband 846 5th Avenue, Baltimore, MD 21227 Melvin R. Johnson, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery | 7/8/2009 4 □ Ponation 5 □ Other (Specify) 21. Cign re of Funeral Service Lipensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anythmia 25 minutes **Physician** Cardine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregr in the past 12 month 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an vasculas diabetes certificate 2 1 1 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director; After this certific: completely filled in by the funeral director, I Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ► R/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner Death 28c. Injury at Work? (Month, Day, Year) tural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 21 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Megnan Checkleu 31. Date filed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

900 82. Registrar's Signature

rack

the

Cuton Avenue

29c. License number

B19916795

Baltimore

29d. Date signed (Month, Day, Year)

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2122

Mayboard

2009

DAEHYUN HO

			State of Maryland	/ Department of Health and M	ental Hygien	9
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	3. Time of Death
	Physicia /Medic		Daehyun	Ko .	July &	2009 01:36
. 200	Examin		4a. Facility Name (If real institution, give street and number)	4b. City, Town, or Location of Death	(1)	. County of Death
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign
	Director		21982 3345 124 2□ 1 82	Yrs. Months Days Hours Min.	DEC 10 193	6 north RESULG
	hand ow			Town or Location		10d. Inside City Limits
	e Mary	ctor	NJ Pisc	ATAWAY		1 □Yes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian, Black, White, etc.
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the "Kadeal Ereminer" ust be notified at	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No	1 ☐ Yes 2 No Specify:	nouri, o.o.,	Specify: TorEAN
21215-0036	2 hours atural cal Ex	ted b	15. Decedent's Education	16a. Decedent's Usual Occupation		Kind of Business/Industry
121	rithin 7 ne. han "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workir life. DO NOT use retired) SiFF DUFER		hanei smetics
d 2.	filed w Hygie other th	Be Co	1 2. 17. Father's Name (First, Middle, Last)	9	(First, Middle, Maide	n Surname)
/lan	uld be Mental arked o	To B	HAN TI TO	BONG	Jum	BANG
Maryland	t 2 sho th and 7 is mo		19a. Informant's Name/Relationship (Type. Print) WIFE	19b. Mailing Address (Street and Number or Rura	I Route Number, City	or Town, State, Zip Code) 0 8854
	s 1 and of Health item 27 other tr		20b. Pla	ice of Disposition (Name of netery, crematory or other place)	ate 20c. l	ocation - City or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the factor Event net results a notified at once.		1 ☐ Burial 2 A Cremation 3 A Removal from State ROS 4 ☐ Donation 5 ☐ Other (Specify)	E HILLCREMATORY 17/11	09 Li	Nden, NJ
Ball	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	I BOLL	Atherford FS PA DD 21213
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	legative Bacterer	ya_	Onset and Death /2 Hows
	/Medical Examiner		Due to (or as a conseque	en 🚅 ():		
	ק ±:	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	inde of):		
	xecute and a-trans	Examiner	Cause (Disease or injury that initiated events c	ence of):	-	
8760,	icate be executed physician and the burial-transit	dical E	d			
9		Med	IF FEMALE:			
Box	The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal c	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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	tw requires that s been signed I s should be deta		Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	2	o use contribute to the cause of death? 2. 70 3 Probably 4 Unknown
Sor	w requ	letec	Cambra Annast		24a. Was an	24b. Were autopsy findings available
- Be	sician: The law certificate has the certificate has the certor, page 2 s	Completed by	Arute Respiratory Pa	ilue	autopsy performed2 1 Yes 2	prior to completion of cause of death? lo 1 □Yes 2 ☒No
Vita	ician: certific ector,	Be	25. Was case referred to medi examiner?	26. Place of Death		
ð	ting Phys n. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 2	28b. Time of 28c. Injury at	me 5 Residence 28d. Describe how inj	6 ☐ Other (Specify) ury occurred
sion	uttending death. ctor: Aft y the fun	catio	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	M 1 □Yes 2 □No		
Division of Vital Records,	l or Att after de Direct	ertification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	lospita t hours uneral ely fillec	O	29a. Certifier (Check only (Ch	ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the Hospital or Attending Physician: The I within E4 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		pate signed (Month, Day, Year)
			* Koun U. Kinsozi	wo DYDTYY		ly 8, 2009
	107		30. Name and address of person who completed cause of drath (Item	23a) (Type, Print)	301 St.	faul Place
	Sta	te	31. Date filed (Month Day, Year) 42. Registrar's Signal	ire sales		Jumy, we didno
	Registr	ar	JUL 0 9 2009 Kengus 18.	M.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Ma	ryland / Depa <i>Cer</i>	tificate of D			eg. No.)	21890
			Decedent's Name (First, Middle, Last)				2. Date of Dear		3. Time of Death
	Physicia /Medic		Dennis T. Keeney Jr		· · · · · · · · · · · · · · · · · · ·		July 2		2:10 AM M
	Examin	er	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice		4b. City, Town, or l Baltim			4c. County of De	ath
	Funeral Director			(In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct 27,	(Year) (irthplace (State or Foreign Country) aryland
pus	*		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
Maryfa	-f sho	tor	MD Harford	Aber	deen				1 ☐ Yes 2√∑ No
h the	or 28a)irec	10e. Street and Number		10f. Zip Code		1	log. Citizen of What (Country?
ath wil	s 23a o	ral	186 E. Bel Air Road	175	21001		!/	USA 44 Bass An	novices In dies
u z iz i 3-0030 filed within 72 hours after death with the Maryland	", or items	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 ☒ Yes 2 □ N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 □Yes 2X No	spanic Origin? (Sp , Mexican, Puerto Specify:	ecity yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. white
13-00 in 72 hour	n "natural ledical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	tion uring most of work	ing	16b. Kind of Busines	s/Industry
d with	giene.	Jom J	Elementary/Secondary (0-12) College (1-4or 5- 12 2		olice off				orcement
se file	d othe	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)	
y la	d Men narke natic	ပ္	Dennis T. Keeney Sr 19a. Informant's Name/Relationship (Type. Print)	10h Mailir	a Address (Street a	Margare		etra r, City or Town, State	Zin Code)
IVIA od 2 st	ulth an 27 is r r traur		Kim Stevens/sister		E. Bel Ai				_
ages 1 ar	Department of Health and Mental Hygiene. Important: If item 22a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place		Date	20c. Location - City	or Town, State
palt.	Departm Importal any injul once.		21. Signature of Funeral Service Licensee	ector :	2. Name and Addres State Anat Baltimore	tomy Boar	d 655 W	. Baltimon	e Street
/1	ysician Medical caminer			the death. Do not ente.		, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Over Year
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ficate be ex	physicia the bur	edical	d						
DIVISION OF VITAL RECORDS, P.O. BOX 00/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	s been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnancy			23d. Date of Month	delivery Day Year
uires that	n signed b Ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac						e to the cause of death? Probably 4 Unknown
VILAI RECOIDS, ician: The law requires t	certificate has bee ector, page 2 shou	Completed					24a. Was autop perfo 1 □Yes	sv prior	autopsy findings available to completion of cause of 19 are 2 No
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OI Phys	r this ral dir	5.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatie	of 28c. Injury	4 ⊔ Nursing ⊓ ⁄at	ome 5 Residence 128d. Describe 1	dence 6 MOther (S	Specify) HOSPICE
VISION	rth. r: Afte e fune	ation	1 □ Natural 5 □ Pending (Month, Da 2 □ Accident investigation	y, Year) Injury	Work	? ⁄es 2 □ No			
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e Hospita	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	lical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or in	nvestigation, in my o	pinion, death occu	rred at the time,	date and place, and	due to the cause(s)
To th	Vithil To th comp	ğ	29b. Signature and title of certifier		29c. License	number		29d. Date signed (M	onth, Day, Year)
			12100 MD		U2	14170		July 2/	2009
			30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	38 N. Eu	taw St	Balti	more M	D 21201
	Sta Registi	ate rar	29b. Signature and title of certifier 30. Name and address of person who completed cause of defending the second of the second	ar's Signature	Mad	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2.001		

			For State Registrar	State of Marylar		artment of F rtificate of		-	giene Reg. No. 00	9	2 8 9 1	
1	n kuntat.		1. Decedent's Name (First, Middle, La	st)			· · · · · · · · · · · · · · · · · · ·	2. Date of De June	_	Xeero	3. Time of Death	
	Physici: Medic/		Lary Adele Lub	er							12:25рм	
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County o			
		18/2	Maria Health C 5. Social Security Number 6. S	Sare Center Fox 7. Age (In yrs.	last hirthday	Baltimo	If Under 24 Hrs.	8 Date of Bir	Baltı) lace (State or Foreign	
	uneral irector			M 2√F 90	Yrs.	Months Days	Hours Min.	8. Date of Bir Month, Da	ry y earl 919	Goun	ry)	
	il COLOI		Usual Residence of Decedent									
ryian	how		10a. State 10b. County		ity, Town or Lo					1	Od. Inside City Limits	
e Ma	a-f s	ctor	MD Baltimo	ore Ba	ltimo	re					1 ☐ Yes 2 ☑ No	
h with th	3a or 28	ai Dire	10e. Street and Number 6401 N. Charle	es St.		10f. Zip Code 21212	2	·	10g. Citizen of W USA	hat Coun	itry?	
7.1.2.13-UU30 d within 72 hours after death with the Maryland olene.	If them 27 is marked other than "natural", or thama 23a or 28a-1 show or other traumatic evant. The Medical Examinat must be nutilised at	by Funeral Director	11. Marital Status →S Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		white,		
72 ho	Isali	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation	cina	16b. Kind of Bus	siness/Inc	dustry	
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liw be	d d	Completed		<u></u>	Adm	inistra					SCHOOLS	
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2 should be filed within and Mental Hydiene.	Is marked other than aumatic evant, the Me	은	George T. Luk				·	1. Opit				
2 sh	Taum.		19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	and Number of Ru rles ST.				Code)	
and tealth	m 27 her t		Bernice Feiling 20a. Method of Disposition	/	Place of Dispo	N. Char	rtes pr	Date	20c. Location - (own State	
permit. Pages 1 a	ant: If Ite ary or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State		matory or other pla	ce) 		200. Eddanon	ony or 10	, otato	
permit.	Important: If Item 27 Is any injury or other tra once.		21. Signal Funeral Service Ice	Wade Nivecto	r S	2. Name and Addre tate Anat altimore,	omy Boar	d 655 W	. Baltimo	ore S	Street	
			23a. Part1. Enter the disease, or com shock, onheart failure. List only	pucations that caused the dea					rrest,		Approximate Interval Between	
/M Exa	physician and physician and streaming transit sthe purial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	Quence of);	Arte	sten	212 C	Q			
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he law requires that	5 0	Completed by Pl	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did	101	abute to th	he cause of death? pably 4 ⊟Unknown	
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e a	02 CA	ם						auto	psy pormed? d	rior to co leath?	impletion of cause of	
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Physician:	recto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3 DOA Ott	26. Place of Dea	-7/	one) idence 6 □Othe	(Cnaa	£.1	
ng Phy	fter this ineral d	on: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of				how injury occurr		<i>y</i>)	
e ndi	or: A	cati	2 ☐ Accident investigation	NO			Yes 2□No					
or Attending Physician: 1 after death.	Direct 1 in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st ify)	reet, factory, office			(Street and Numbe wn, State)	ar or Rura	al Route Number,	
Mospital 24 hours	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Pl	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, dea nation and/or in	th occurred at the travestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as s and due t	itated. o the cause(s)	
To the	To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	1 (Month,	Day, Year)	
			to ella			10	010318	30	line	31	2009	
			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print)	10	W.V.	11	- 100	C=31 1910 2	
		Y.	GIND FREEZE	nan 470	1 1	1 Chai	ally 3	y 50	Homes	7. FY	10 2110	
	Sta		31. Date filed (Month, Day, Year)	/32. Registrar's Sign	ature Law	Ved.		-0000**				
	Registr	ar	.101 0 9 2009	1 Dener P	· japan							

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 6, ^{Day} 2009 2:00 PM **Physician** Gwendolyn Werth Luttrell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Kensington 9820 Culver Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 30, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days **Funeral** Aug 1927 1 □ M 2√2 F Mississouri Yrs 81 523-32-7819 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 X No Kensington Director Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20895 9408 Byeforde Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after an of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: Specify: White Baltimore, Maryland 21215-0036 ò 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Geological Survey <u>Geologist</u> 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked other ar traumatic event, L 17. Father's Name (First, Middle, Last) Be Laura Belle Nicholas Lewis Werth မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9408 Byeforde Rd. Kensington, MD 20895 John Lore Luttrell/husband permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
000ce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 07/07/09 Woodbine, MD GO NATE MANUES CREMENTATION Service P.O. Box 784 21. Signature of Funeral Service Licensee Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 the Approximate Interval Between Onset and Death 23a. Part 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 years aGlioblastoma Multiforme **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23d. Date of delivery If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant in the past 12 months? Month Year 3 Ectopic pregnancy Day ρ 5 Other (specify) the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2√ No certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical Be daughters Other: 4 Nursing Home 5 Residence 6 Other (Specify) home Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes 2 No P this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours and war.

To the Funeral Director: Aft 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cer 067421 NO d address of person who completed cause of death (Item 23a) (Type, Print) 30. Name BLOG. 10 RM 12N 226 10 CENTER Da. HAYS

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Denne S. Garle

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1610 M Delphine Catherine Mandella 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Seasons Hospice Randa11stown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 🗆 M 🗓 K 212-30-2376 76 Mar. 4, 1933 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 1 ☐ Yes 2X ☐XNo Marriottsville MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21104 U.S.A. 1980 Barley Rd. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes XX No Specify: Specify: White XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Food Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julius Taylor Louisa Bolties 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1982 Barley Rd. Marriottsville, MD 21104 Michael S. Mandella / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 7/13/09 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of uneral Service License 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Glioblastoma disease or condition resulting in death) Due to (or as a consequence of): e of delivery Day ribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 ဩNo er (Specify) HOSPICE

Physician /Medical Examiner requires that the death certificate be executed burial-transi and

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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23a

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permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Director

Funeral

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Completed

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traumatic event, the Medical Exercitive must be notified at

death with the Maryland

filed within 72 hours after thygiene. Hygiene.

Baltimore, Maryland 21215-0036

Examiner the attending physician hed for use as the burial Physician/Medical detached signed by 1 d be detach 2 icate has been si , page 2 should b Be Completed certificate director, Certification: To After this funeral c To the Hospital or Attending Pł within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1	I death 3 Ectopic pre	gnancy cify)	23d. Dat
Part II. Other significant conditions o	ontributing to death but not resu	ulting in the underlying cau	se given in Part I.	23e. Did tobacco use control 1 Yes 2 No
				24a. Was an 24b. No performed?
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA	Other: 4 I Nursing	Home 5 ☐ Residence 6 🗖 Oth
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)		c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how injury occurr
3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, o	office	28f. Location (Street and Numb City or Town, State)

Medical

(Check only one)

29a. Certifier

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

death (Item 23a) (Type, Print) 30. Name and address of person who completed

2835 Smith Avonus Svite 200 Baltimers MD 31. Date filed (Month, Day,

1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Mary J. Miller

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Physicia		Decedent's Name (First, Middle, La	ist)			4		2	Date of Death Month	Day	Year	3. Time of Death
Physicia /Medic		Mary	7.		Mil	ler					2009	6:05 PM
Examin		4a. Facility Name (If not institution, gi		1	<u>^ </u>	4b. City, Town, o	r Location	of Death	·	4c. Count	y of Death	
		Johns Hopkins B 5. Social Security Number 6.	ayview Me	dical e (In yrs. las	Lente t birthday	If Under 1 Year	If Under	24 Hrs 10	Date of Birth		Q Rinth	niace (State or Foreign
Funeral Director		215-86-5193	1 M 2 K	49		Months Days	Hours	Min.	Date of Birth (Month, Day, 13)	Year) 1959	Man	place (State or Foreign intry) Land
		Usual Residence of Decedent		7/					incy 13	1777	nwa	Jeanu
rylan show	_	10a. State 10b. County		10c. City,	Town or Lo							10d. Inside City Limits
Ba-fs	Scto	Maryland Baltin	nore		Dund							1 □ Yes 2 □ X No
vith th	Funeral Director	10e. Street and Number				10f. Zip Code	4222		10	g. Citizen of	What Cou	intry?
eath v	eral	6836 Dunlar Road	12. Was Decedent B	Ever in LLC	12.1		1222	igin? /Speci	fy Vas or No-	USA	oo - Amer	ican Indian,
fter de	핊	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?			Was Decedent of H If Yes, specify Cub	an, Mexicai	n, Puerto Ric	can, etc.)		ck, White	etc.
urs a all', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 □ (No	Specify:			Specia	fy: Wh	ite
be filed within 72 hours after death with the Marylar the Hygiene. The Hygiene. The doublet than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Madeal Evan that the rutilised at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occup	oation during mos	t of working	1	6b. Kind of E	Business/II	ndustry
ine.	du l	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done DO NOT use retire	d)			Δ.	11 -	
Hygie Thert		10 years 17. Father's Name (First, Middle, Las	t)		H	ousewife	18 Moth	ar's Name //	First, Middle, M.		Home	
d be f antal red o	Be C	John J. Dolls	,				l		Gorski		110)	
ie, way judica 212.15-0050 I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The file is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evandre.	ဍ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural i	Route Number,	City or Town	, State, Z	ip Code)
and 2: and 2: lealth a m 27 is her trau		Rickie Miller	Husband			Dunbar i				-		
permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra	1	20a. Method of Disposition	7	20b. Plac		sition (Name of matory or other pla		July		0c. Location		
Pages ment of ant: If Its ury or o		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Speci</i>				Crematory		2009	Ba	eltimo	re, P	laryland
permit. Departimonts any injury once.		21. Signature of Ameral Service Lice	pee					il Hom	e Of Du	ndalk	P. A.	
1 % Q E # 9		Joseph C	h								Mary	land 21222
		23a. Part 1 Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. ne.	Do not ent	er the mode of dyi	ng, such as	cardiac or r	respiratory arre	st,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	a. Int	race	rebo	al hemi	archo	ioe_				7 days
/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):			J				
	<u>-</u>	Sequentially list conditions,	b. COBO Due to (or 20)	Ulop	othy	/					- 11	GMONTHS
uted J Insit	Examiner	Cause (Disease or injury	Non-o	ادمه	olic	Steat	ahen	atitis	-			Over
exection and and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):	0 . 0001	517 4 2		,			1-9603
eath certificate be executed attending physician and for use as the burial-transit	cal		_ d									
ertifica ing ph	cian/Medical	IF FEMALE:										
leath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal d	eath 3[☐ Ectopic pregnand	су				ate of deli Ionth	very Day Year
		1 ☐ Yes 2 MNo 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5	Other (specify) _				101	OFRIT	Day Teal
The law requires that the drate has been signed by the oage 2 should be detached	Physi	Part II. Other significant conditions	contributing to death bu	ut not resulti	na in the u	nderlying cause giv	en in Part I		23e. Did toba	acco use cor	ntribute to	the cause of death?
uires d be	d by	,	•			,,			1 ☐ Yes	2 No	3 □ Pro	obably 4 ☐ Unknown
w requir been s should I	Completed								24a. Was an	1 24h	Word au	opsy findings available
he lav e has ige 2	d m								autopsy perform	ed?	prior to c death?	ompletion of cause of
sician: The certificate h	ပိ	25. Was case referred to medical					26 Place	of Dooth (1 ☐ Yes 2 Check only one	No	1 □ Yes	2 □No
ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: Na Inpatie	nt 2 🗆 EF	R/Outpatier	nt 3 DOA Oth	201		e 5 ☐ Resider		her (Snec	rify)
ig Phys ter this neral dir		27. Manner of Death	28a. Date of Inju	ry 2	8b. Time of		ry at		d. Describe hov			ny)
endir sath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation	n	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Hijory		Yes 2	No				
r Att	Certification:	3 Suicide 6 Could not be determined		ry - At home: (Specify)	e, farm, str	eet, factory, office		28	f. Location (Street) City or Town,	eet and Num State)	ber or Ru	ral Route Number,
oital o urs af sral D												
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinatio	edge, deat n and/or in	n occurred at the ti vestigation, in my	me, date a opinion, de:	nd place, an ath occurred	id due to the ca I at the time, da	use(s) and r te and place	nanner as , and due	stated. to the cause(s)
o the inthin ;	Mec	29b. Signature and title of certifier	and manner sta	IIGU.		29c. Licens	se number		29	d. Date sign	ed (Month	ı, Day, Year)
F \$ F 8		1225	>	-		-		000		T. 1/ -	60	2009
7 ()		30. Name and address of person who	completed cause of de	eath (Item 2	:3a) (Type.) (J .	,00-1	0,	
71		PASLO REC'INE	S MD 4			TEN AVEN	NE B	ALTIV	none	MA	212	24
Sta	te	31. Date filed (Month, DUL ear) 9	2000 32. Registra	ar's Signatur	'e				-,-			•
Registra	ar	205 0 3	LUUS New	wa	1. 1	barker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

			State of Maryland / Department of Her State Certificate of Department of Heronal Certificate of Department of Department of Heronal Certificate of Department of Heronal Certificate of Department of Heronal Certificate of Department of Heronal Certificate of Department of Heronal Certificate of Department		ental Hygien Reg. N	- 2005	21895
×		7	1. Decedent's Name (First, Middle, Last)	- 2	2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		Hector I. Marcos		07 01	2009	641PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	4	c. County of Deat	h
				erstown If Under 24 Hrs. 8	B. Date of Birth		imore hplace (State or Foreign
	Funeral		1 2 F Yrs Months Days	Hours Min.	(Month, Day, Year	r) Co	untry) Peru
	Director		216-13-5559 72 Tis. Usual Residence of Decedent		01-77-7	776	reru
	yland now at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mar a-fst	cto	MD Baltimore Reistersto	wn			1 ☐ Yes 2 K No
	or 28	Dire	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Co	untry?
	ath w	ral	*	136	16 . 3/ 81-	U . S	S.A.
	er de items ner m	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	, Mexican, Puerto R	ican, etc.)	Black, White	
30	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by F	1 INSTANCE IN INS	Specify:		Specify:	Peruvian
5-0036	2 hou atura ical E	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	ion	16b.	Kind of Business/	Industry
בוב	thin 7 e. an "n Medi	Completed	(Specify only highest grade completed) (Give kind of work done dure life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	ning most of working	9		
7	ed wil	S	12 Co Owner				rtation Co
yland	be filled High description of the contract of	Be	The date of table (1994, 1995), 2009	_	(First, Middle, Maide	en Surname)	
$\frac{8}{5}$	nould I Mer narke	은	Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and	Unknov		or Town State	Zin Codo)
Zaz	d 2 sk th and 7 Is n traun						ip Code)
<u>က်</u>	1 an Heal tem 2		Patricia N. Marcos Daughter 5 Sunup Court 20a. Method of Disposition (Name of	Da		21136 Location - City or	Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Cremation	i .	/09	Hampstea	ad. MD
	ortar Injur		21. Signature of Fuperal Syrvice Licensee 22. Name and Address		1824 Reist		
ñ	Dep Imp		ELINE FUNER		Reisters		21136
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death UCOV
3)	/Medical		resulting in death) Due to (or as a consequence of):				7
	Examiner	L	Sequentially list conditions, b.				
- 4	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause I Unsease or multiple.				
	and and II-tran	xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8/60	cate be executed physician and the burial-transit	dicalE					
89	ificate g phy: as the	edic					
ROX	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of de	
	deat e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
J.	The law requires that the tee has been signed by the bage 2 should be detache	hys	9 LI UNKNOWN		00- 5-14-1		the server of death 0
<u>v</u>	res th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given array Artery Disease	ıın Panı.			o the cause of death?
5	requi	sted				`	
Vital Hecords,	e law has b	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u></u>					performeda 1 Yes 2 1	No 1 ☐ Yes	3 2 □ No
=	Physiclan: The law this certificate has trail director, page 2 s	Be	examiner? Hospital: Other	26. Place of Death	1-	a 🗆 00 11 12 12	· ·
Ö	Phy this ral d	5	I Impatient 2 ENOutpatient 3 BOA	4 ☐ Nursing Hom	ne 5 Residence 8d. Describe how in		ecity)
C							
S N	or Attend after death. Director: /	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Street City or Town, Sta	and Number or R	ural Route Number,
5	talor s afte al Dli ed in	Cert	,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,				
	To the Hospital or At within 24 hours after d To the Funeral Direc' completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.	e, date and place, a inion, death occurre	and due to the cause and at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
	To the vithin To the comple	Mec	29b. Signature applittle of certifier 29c. License r	number	29d. [Date signed (Mon	th, Day, Year)
	->-0		I fould come of	00/696	TI	07/07	12005
7	10 1		(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ // > -	1 +h = -	4.1	/ /
	V		Barbers A Wilran, MD 705 Digital 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	11/1/12,	CIMPLIC	ivu, sud	
į	Sta Regista		111 0 9 2008 Aug. A. Sares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SERTRUSE 2009 05:30AN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FRS 10 If Under 24 Hrs. EVW00D 10 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code ō U.5.A or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify: þ 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau RTITUK DRAGE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 △Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician a hed for use as the burial-Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a o. ☐Yes 2☐No 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Unknown 1 Tyes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate 2 No 1 □ Yes Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITHLESA

DHMH 17 Rev 1/2001

State Registrar

		For State Registrar				l / Depa	artment	nk. Ensure / of Health and <i>of Death</i>	Mental Hy	_	09	21897
Physicia		Decedent's Name	,	e V. N	ladol	nv Ji	r.		2. Date of De Month July	Day Day 5 2009	Year	3. Time of Death 8:30 A M
/Medic Examin			f not institution, giv Kwood La	e street and number) ne	e (In yrs. la				th	4c. County Ba	time	
Funeral Director		218-42- Usual Residence of	-2329 1	M 2□ F	62	Yrs.		lays Hours Min		ay, Year)	Cou	ntry) MD
/aryland f show ed at	tor	10a. State MD	10b. County Baltim	nore	10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 🌋 No
with the 3a or 28a-	Funeral Director	10e. Street and Nur 933 Fc	nber Oxwood I	ane			10f. Zip C	21221		10g. Citizen of		ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene are some and the state of the state o	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 🔀 Married 4 🗌 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deceder f Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)		ce - Ameri ck, White, y: Wh	
thin 72 hours. e. an "natura Medical E	Completed	(Spec	15. Decedent's Edify only highest grand	lucation de completed) College (1-4or 5	i+)	(Give life. L		done during most of wo etired)	orking	16b. Kind of B		
be filed wit tal Hygien d other th	Be	12th 17. Father's Name	1 (First, Middle, Last,	1		Elec	ctric	18. Mother's Na	me (First, Middle	, Maiden Surnai	nerc	laı
d 2 should the and Men 27 is marked traumatic	To	19a. Informant's Na			r.			Shirl treet and Number or Fi wood Lane		per, City or Town		
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disp	oosition	Removal from State	CO	ace of Dispo	sition (Name	of	Date	20c. Location	- City or T	
Physician		Immediate Cause (he disease, or convert failure. List only	Larrel	Gh i yle death.	Do not ent	Conne	elly Fune of dying, such as cardia	c or respiratory a	me of I		
/Medical Examiner	.	resulting in death) Sequentially list cor	nditions,	Due to (or as			RY	ARTER:	7 DIS	SME		
ficate be executed physician and sthe burial-transit	lical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I		Due to (or as Due to (or as								
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pred ☐ Other (spec				ate of delive	very Day Year
quires that en signed b	þ		icant conditions	contributing to death b		_	nderlying cau	se given in Part I.		tobacco use cor Yes 2 No	*	the cause of death?
n: The law requir ficate has been si r, page 2 should b	Completed								1 □Yes	opsy ormed? 2 □ No	prior to c death?	opsy findings available ompletion of cause of
/sicial s certi	o Be	25. Was case reference examiner? 1 ☐ Yes 2 ☐		Hospital:	ent 2∏ F	R/Outnatier	nt 3 🗆 DOA	Othor	eath (Check only Home 5 Res		har (Snoo	i6.)
og Phy ter thi	n: To	27. Manner of Deat	h	28a. Date of Inju (Month, Da	iry 2	28b. Time of		Injury at Work?		how injury occu		
al or Attendir s after death. Il Director: Al	Certification:	1	5 Pending investigation 6 Could not be determined	n			M eet, factory, o	1 ☐ Yes 2 ☐ No		(Street and Num wn, State)	ber or Ru	ral Route Number,
ne Hospit n 24 hour ne Funeri	edical	29a. Certifier (Check only one)	1 ☐ Certifying Pt 2 ☐ Medical Exar	nysician: To the best niner: On the basis o and manner sta	f examinati	/ledge, deat on and/or in	h occurred at vestigation, in	the time, date and pla my opinion, death occ	ce, and due to the curred at the time	e cause(s) and n , date and place	nanner as , and due	stated. to the cause(s)
To ti withi To ti com	Me	29b. Signature and	20	70				icense number		29d. Date sign	ed (Month	, Day, Year) 2009
10		30. Name and addr	ess of person who	completed cause of d	leath (Item	23a) (Type,	Print)	13306 12 Rd Sw	Je aso	Barton	ne 1	NO 21237
Sta Registr		31. Date filed (Mon	th, Day, Yearly -	32. pegistr	ar's Signatu	B L	0.00					

DHMH 17 Rev 1/2001

09-05294 C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Connor Peterson	State of Maryland / Department of Health and Mental F 1-For State Certificate of Death	Reg. No. 2009 2189
Physician/	Registrar	Date of Death 3. Time of Death
Medical Examine	Jarrett Connor Peterson	July 5, 2009
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea St. Josephs Hospital Towson	4c. County of Death Baltimore County
Funcial	St. Josephs Hospital 10wson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	
Funeral Director	212-35-2497 1X M 2 F 17 Yrs. Months Days Hours M	Dec. 2 1991 Country) MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
*	MD Baltimore Lutherville	1 Yes 2 X No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If iten 27 is marked other than "natural", or itens 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 21093	10g. Citizen of What Country? USA
r death with th		Specify Yes or Norto Rican, etc.) 14. Race - American Indian, Black, White, etc.
fler de l', or ler mu		Specify: white
ours aft aftural' xamine		
TOTE, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Heath and Mental Hygiene. 11. If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by I	Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a Self Employed	Landscaping
15-00; filed with Hygiene d other t , the Mec		rme (First, Middle, Maiden Surname)
D 2121 should be fil and Mental It 7 is marked natic event, et		na Lynn Butler or Rural Route Number, City or Town, State, Zip Code)
MD 3	· · · · · · · · · · · · · · · · · · ·	, Phoenix, MD 21131
ore, MCss I and 2 s of Health at If item 27	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State / 10 / 09
Pages Pages ment of tant: It		l Gardens Timonium, MD
Baltimore, ME permit Pages I and 2 s Department of Health a Important: If iten 27 injury or other (raum)	22 Name and Address of Easility	Home of Dulaney Valley, Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease a. Multiple injuries	Death
2	or condition resulting in death) Due to (or as a consequence of):	
Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted nisit	cause. Enter Underlying Cause (Disease or injury that inflated Due to (or as a consequence of):	
nd ransit	events resulting in death) Last Due to (or as a consequence of).	
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BO) e death the att	1 Yes 2 No 9 Unknown 9 Unknown	Do. Did to be a superceptibility to the course of doubt?
Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be executed or attending Physician and retal Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit Certification: To Be Completed by Physician Medical Experience of the property of the physician Phys		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
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al R	25. Was case referred to medical 26. Place of Death (Che	eck only one)
f Vita Physicis or this ce ral direc	1 Ves 2 No Impatient 2 ER/Outpatient 3 DOA 4 No	ursing Home 5 Residence 6 Other:
J of ling P		subject struck by light rail
Siol Attend death death sector:	Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	
Division o ital or Attending Lrs after death. ral Director: After lied in by the function:	3 Suicide 6 Could not be determined (Specify) light rail tracks	28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 Ridgely Rd West Lutherville, MD
	20g Cortifier	and due to the cause(s) and manner as stated.
To the Ho within 24 To the Fin completely	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	July 6, 2009
30K perd	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	21201
Staf		
Stat Registra	1111 0 0 00000 12 Il BRI Re	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:20P M 2009 octor 07 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore lanor Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Months Days Hours 218-07-3822 Director Usual Residence of Decedent 10d. Inside City_Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 □ No Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Newer Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Healt 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Moten ပ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type: Granddaupter Owings Mills MD 21117 20c. Sociation - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 7-8-09 Balto. MD 4 ☐ Donation 5 ☐ Other (Specify) . Greene Funeral Services 21. Signature of Funeral Service License Ba HO. MD 21229 Balto. Approximate Interval Between Onset and Death FEW MONTH 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final THRIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ADVANCE DEMENTIA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 □ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifia

31. Date filed (Month, Day, Year)

MATEEN

MA

10802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWAN

29c. License number

D0062634

29d. Date signed (Month, Day, Year)

COLUMBIA MA

8, 2009

21044

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Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm. A deal Exaction of the rottling at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	Registrar					Cer	tificate	oi Deair	1		Reg. No				
an cal	1. Decedent's Name	e (First, Midd	lle, Last)	Por	NEIL					2. Date of De Month	ath Day		Year 2009		of Death 05 AM
er	4a. Facility Name (//	f not institutio	on, give street and n	ımber)			4b. City, Tov	n, or Location	of Death	-	4c.	County	y of Death		
	2865 Ma	yfie]	ld Ave.				Balt	imore				n.	/a		
	5. Social Security N	umber	6. Sex	7. Age	(In yrs. last birt	hday)	If Under 1 Y	ear If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	th Year)			place (Stat	e or Foreign
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	21. Signature of Fu	neral Service	Licensee / //			22.	Name and A	ddress of Faci	ility	10,2	.003		arcc	····	MG •
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	snock, or nea	rt failure. Lis	t only one cause on	each line.	•									Onset ar	Between
	Immediate Cause (disease or conditio	(Final n	a /	VE-	TASTA	TI	C E	AHAO	GEAL	CA	NC	in		1	ONTA
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ian	23b. Was decedent in the past 12		1 ☐ Live	birth 2	Fetal death	3 🗆	Ectopic preg	nancy					ate of deliv Ionth	ery Day	Year
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ü	27. Manner of Deatl	h 5 □ Pendii	/8.4	of Injury onth, Day,	Year) 28b. T	ime of jury	28c.	injury at Work?	2	8d. Describe	how inju	ry occu	rred		
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iţi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deterr	mined 286. Plat	e of Injury ling, etc.	/ - At home, far	m, stre	et, factory, of	ice	2	8f. Location (Street a	nd Num	ber or Run	al Route N	umber,
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a	29a. Certifier	1 Certifyi	ing Physician: To th	e best of	my knowledge	, death	occurred at	he time, date	and place, a	and due to the	cause(s	s) and n	nanner as	stated.	
Medical Certification: To	(Check only one)	2 Medica	i Examiner: On the	basis of e	xamination and	d/or inv	estigation, in	my opinion, d	eath occurre	ed at the time,	, date an	d place	, and due t	o the caus	e(s)
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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 2009 9:20 William Camden Perna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/9/1930 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Yrs. Washington DC 579-40-6967 Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any highly or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Montgomery Potomac Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11820 Gainsborough Road 20854 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architecture Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Perna Iva Virginia Riley မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11820 Gainsborough Rd. Potomac, MD 20854 Norma T. Perna, wife 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 7/3/2009 Beltsville, MD 21. Signature of Funeral Sarvice License 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) oronan Due to (or as a consequen ± of): /Medical Examiner Sequentially list conditions if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a conse uence of): nding physician and use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 1 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66896

Registrar DHMH 17 Rev 1/2001

State

Matthew Leonard, MD 8600 Old Georgetown Rd. Bethesda, MD 20716

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #3 & 24a, per MD 9893 7/9/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Deathunk 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9 09 Physician Kosenburg 26 М /Medical 4c. County of Death Examiner tardens Nursing Home tatti More If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/28/19/0 9. Birthplace (State or Foreign Country) **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. 1 Yes 2 No BaHiMore Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Giv Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number Route Number, City or Town, State Knother ethod of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State Zion 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License e, or complications that caused the List only one cause on each line 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR THEROSCLEROTIC DISEAGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ned by the side detached f 9 Unknown 9 Unknown the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performe 1 Yes 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Graing Home 5 Residence 6 Other (Specify) 2[**T** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MID D0060 520 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) PHILADELPHIA 9/06 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Ridgely Ethe1 12:52A Ju1y 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Towson Baltimore Gilchrist Hospice Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours Min 86 Jan. 11,1923 215-14-1167 MD Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Last Gate 21117 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? 1 ∐Yes 2 X No Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Suzanna B. Hape 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Dunkle, Sr. Friend 2464 Caves Road, Owings Mills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 7/7/09 Baltimore, MD 21. Sign-ture ... Fineral Service Licensee. 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 3a. lart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMPHY 52 4EARS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year

Physician /Medical Examiner

permit. Pages 1 and 2 st Department of Heatth and Important: If item 27 is n any injury or other traun once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last

Examiner requires that the death certificate be executed burial-transi and attending physician Physician/Medical the

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signed by the a d be detached for

has been ye 2 should

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within 24 hours after death.

To the Funeral Director: /

After thi funeral

page 2 certificate

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

Completed

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Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

'is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

P.O. Box 68760.

of Vital Records,

Division

or Attending Physician:

To the Hospital

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ite Modical Examinar mat be notified at

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

4 ☐ Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Probably 4 Unknown

24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐Yes 2 100 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 700

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 2 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

D64395

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 WEST TOWSONTOWN BLUD BALTIMORE, MO 21204 DANIEUE RMAN, MO 000 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MAXINE 2009 TOLBERT SMITH July 10:00a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MANOR CARE-ROLLING PARK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2XXF INDIANA Director 1932 215-28-2345 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location other traumatic event. The Wedical Examiner hast be notified at 1XIYes 2 ☐ No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3507 W. NORTHERN PKWY U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2XXNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: BLACK þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE UNION MEMORIAL HOSP. 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT TOLBERT P ELIZABETH GURRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. Deborah Randolph/Daughter 3507 W. Northern Pkwy, Baltimore, Md., 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Neurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 07-13-09 BALTIMORE, MARYLAND 21. Signature of uneral Service Lo WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Kollen 1206 W NORTH AVENUE 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final 2 hEIMER'S **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐Yes 2 No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown VASCULAR Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MiD D0159107

State Registrar

DHMH 17 Rev 1/2001

CENTER PRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

BUSINESS

32. Restrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 12:00 PM -00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 5. Social Security Number 6. Sex If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Months Hours Min. Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified an once. 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 □ Divorced act Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I daughter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funera Home Balto, Md 23a. Part I. Enter the dis 7 se, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail the. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final MI **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed DIFF COLITIS Due to (or as a consequence of): Box 68760, Physician/Medical UROSEPS IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 □ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 Z No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C. 2009

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

W. J

32. Registraris Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** George W. Stuprich 2009 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kosedale Baltimore Franklin HOSPITA uare Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In vrs. last birthday **Funeral** Hours 1**⊠**M 2□ F Davs 217-40-3869 64 Director March 7,1945 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Marylan 10a State Funeral Director Baltimore 1 ☐ Yes 2 ☑ No Middle River 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 4057 Rustico Road 21220 ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Modical Examiner must be USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes ≱☐ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lithography Machine Operator 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Stuprich ပ Mildred Cogal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Stuprich /wife Rustico Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 7/11/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Par I. Enter the disease of complications that cause in e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** /Medical Due to (or as a consequence of): Examiner oronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine sician and burial-trans pertension Die to (or as a consequence of): attending physician for use as the buria Physician/Medical E FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown After this certificate has been situated funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 □Yes 2 ☑No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ▼Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 21237 Ronomo State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, And or Attending Physician: The law requires that the death certificate be executed.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 3:45 PM 2009 Tricia 76 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore N/A 07 ical Center niversity Cry one If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 □ XF Days Hours Min 209-30-2002 68 March 25,1941 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏋 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 925 Sunnybrook Drive 21060 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No 1962— If Yes, Give Year or Dates: 1965 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. White 3 Widowed 4 Divorced 1965 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Macey Viola Wacera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edmund Slezak / Husband 925 Sunnybrook Drive Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park July 10, 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner Examiner requires that the death certificate be execute the burial-tran and Division of Vital Records, P.O. Box 68760, physician Physician/Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Ensigner must be notified at

and Mental Hygiene.

Department of Health a Important: If item 27 is any Injury or other tra once.

Pages 1

should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

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Completed by

Be

Certification: To

Medical

State Registrar 29b. Signature and title of certifie

Jas 31. Date filed (Month, Day,

3 V Name and address of person who completed cause of death (Item 23a) (Type, Print)

disease or condition resulting in death)	a. Ineumonia		
resulting in death)	Due to (or as a consequence of):		
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Cause (Disease or nijury that initiated events resulting in death) Last	C		
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 I No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions co Renal Failur,	ntributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	
25. Was case referred to medical	26, Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
(Check only 2 Medical Exami	rsician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occur	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)

29c. License numbe

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

or Attending Physician;

within 24 hours after ucc...
To the Funeral Director: After-To the Hospital

ORIGINAL

			For State Registrar	State of Ma	ryland	-	artment of F ctificate of		Mental Hy	/giene Reg. No	0000	219	0.8
	Physici	an	1. Decedent's Name (First, Middle, La.	st)					2. Date of D Month	eath Da	ay Year	3. Time of I	
	/Medic		Victoria	Sutt	on				June	_		0028	A M
	Examir	er	4a. Facility Name (If not institution, giv				4b. City, Town, o		ith		. County of Death		
	5		1400 Fenwick Aver 5. Social Security Number 6. S		(In vrs. la	st birthday)	Silver Under 1 Year	Spring If Under 24 Hr	S. 8. Date of B		ontgomery 9. Birtho	lace (State or	Foreign
	Funeral Director				78	Yrs.	Months Days	Hours Mir		4,19	30 Richt	nond VA	
	yland now		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City	y Limits
	a-fs	ctor	Maryland Montgome:	cy	Silv	er Sp	ring					XXYes	2∐No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cour	try?	
	ath wi		1400 Fenwick Aven	ue #!	503		20910				ted State	S	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Widcall Eventre or ust be rediffed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4\(\frac{1}{2} \) Divorced	12. Was Decedent E Armed Forces? 1			Vas Decedent of H fYes, specify Cuba I□Yes 2201No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto <u>Rican, etc.)</u>	0-	14. Race - Americ Black, White, of Specify:		
Ŏ	2 hou	ted	15. Decedent's Ed	lucation		16a. Deced	lent's Usual Occup	pation	and the se	16b. H	Kind of Business/Inc	lustry	
21218	l within 7 giene. r than "n	Completed	(Specify only highest graves and secondary (0-12) Ninth	College (1-4or 5+ None	+)	Chef	kind of work done	during most of w d)	orking	East	ern Star	- Wasl	n DC
þ	e filec al Hy othe vent,	Be C	17. Father's Name (First, Middle, Last,					18. Mother's Na	ime (First, Middle	e, Maidei	n Surname)		
Maryland	uld b Menta arked atic e	10	Unknown Unknown					Eve1yn	(Unknov	m)			
<u>ar</u>	2 sho and is ma	1	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	g Address (Street	and Number or I	Rural Route Num	ber, City	or Town, State, Zip	Code)	
≥,	and lealth m 27		Jalannia Sutton/D	aughter							Californi		7
Baltimore,	ges 1 If of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐	Removal from State			sition (Name of natory or other place		ı1y 2009		ocation - City or To		
ij	t. Partmen rtmen rtant:		4 □ Donation 5 □ Other (Specific		Rive		Park Cr	, -	1	1	erdale Ma	•	
Bal	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is o any Injury or other trau		21. Signature of Funeral Service Licer	see		- 1					on Funera ton DC 20		Inc
	222 10 0		23a Part 1 Enter the disease or com	plications that caused t	the chath						LOII DC 20		
4	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	MQ_{i}	nlu	celler	Illy	Thmes	2		Approximate Interval Betw Onset and D	reen eath
100	Examiner			h		MIN	neone	lial 1	Onla1	1 10	m		
	p .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	stice off.			- July	تعمي			
1.	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		V			U				
8760,	oe execian a		resuming in death) Last	Due to (or as a	conseque	ence of):							
876	at See	dical		d									
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 LENo 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal o	death 3	Ectopic pregnance Other (specify)	у			23d. Date of delive Month	•	ear
σ.	that the led by detac		Part II. Other significant conditions of	ontributing to death bu	not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to the	ne cause of de	eath?
rds	uires n sigr ld be	d by	Diabele	Mell	ell	しつ			1 🗆	Yes 2	2 □ No 3 □ Prot	ably 4 🗆 U	nknown
S	w rec	Completed	Alorh or low	MOD					24a, Wa	s an	24b. Were auto	psy findings a	vailable
R	The la te ha: age 2	E C	Aylecter				· · · · ·		per	opsy ormed?	death?		use of
ta	an:] tifica tor, p	Be C	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only		o 1 □Yes	2 X No	
>	yslcl is cer direct	To B	examiner? 1 🗆 Yes 2 🗖 No	Hospital:	nt 2 🗆 E	R/Outpatier	t 3 DOA Oth	Ori			6 ☐ Other (Specif	·v}	-
0	ig Ph ter th neral		27. Man or of Death	28a. Date of Injury (Month, Day)		28b. Time of Injury			28d. Describe			,,,	
iğ	endir ath. or: Af he fur	atic	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation			,,		Yes 2 □ No					
Division of Vital Records,	al or Att s after de il Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injui building, etc.	ry - At hon . <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location City or To	(Street a wn, Stat	and Number or Rura le)	l Route Numb	oer,
	ne Hospit n 24 hour ne Funera pletely fille	Medical (29a. Certifylng Pr (Check only one) 12 Certifylng Pr 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examinati	/ledge, deatl on and/or in	n occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to th curred at the time	e cause(e, date ar	s) and manner as and place, and due to	tated. the cause(s)	
	To the within To the comp	M	29b. Signature and title of certifier				29c. Licens	se number	17	29d. D	ate signed (Month,	Day Year)	
	2		30. Name and address of person who Smith Ho M.D. 761					a Park,	MD 2091	2	/ /	/	

2 State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ,30 2009 1158 /Medical County of Death 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c Examiner dinton RANCH Wood TERRACE 600198 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Months Days Hours Min 1 □ M 2 X F Ktober 22,1957 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at 1. Yes 2 □ No Funeral Director ARY/And 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ş 3 Widowed 4 Divorced Completed 16b. Kin of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Kaner 1246 18, Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ELNICE traumatic ပ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Clinton DRICE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 Removal from State fingforse, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ince Funeral Ser NANCY M. WAILING FUNERAL SER LAW 3405 W. FRANKLIN SHEET - BALTIMONE 21. Signature of Funeral Service Licensee MARY/And or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a, Part 1, Enter the dise is shock, or heart fail e Approximate Interval Between Onset and Death Cervical cancer **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autonsy perform certificate 2 No 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 5 ster Home) Hospital: 15 Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce du

Registrar DHMH 17 Rev 1/2001 HOPKINS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIPSON

LUAN

31. Date filed (Month, Day,

State

09-05203 Michael Saunders

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Cert	tificate of	Dea	th			F	leg. No.	Com C	0	J 5	1 / 1
Physic	ian/	Decedent's Name (First, Mide	dle,Last)								Date of Dea	ath		3	. Time of Dea	ath
/ledical Exam		Michael Freema	n Sa	unders	Sr. Mic	hael Sa	aund	lers		_],	Month July 2, 20	Day 109	Year		0804 hrs	;
		4a. Facility Name (if not instituti						Town, or Lo	ocation of				ounty of [Death		
		Bon Secours Hospita	l				Balti	more				l n	ı/a			
Funera	1	5. Social Security Number	6. Sex	7.7	Age (In yrs. las	st birthday)	If Un	der 1 Year	If Under	24Hrs.	8. Date of B			g. Birthr	olace (State o	or Foreign
Directo		,					Mont		Hours	1.6			1	Coun	itry)	
Directo		212–70–6449	1 X N	M 2 F	4:	9 Yrs.					01/15	/ 1960		VA		
8		Usual Residence of Decedent 10a, State 10b, County			10. 0: -	F								- 12	0.1.11101	1 1 1 - 11 -
w an	1				Tuc. City,	Fown or Location		timor	^					- 1	0d. Inside Cit	
and sho	5	MD n/	a				Dal	CIHOL	е						1 X Yes 2	2 No
Aaryland 28a-f show any 1 at once.	ector	10e. Street and Number					10f. Z	p Code				10g. Citizer	of What	Countr	y?	
ith the Maryland	ᄚ	1914 West Nort	h Av	<i>r</i> enue			21	217				USA				
with with 18 23	<u> </u>	11. Marital Status		12. Was Decede	ent Ever in U.S	6. 13. Was	Deced	lent of Hispa	anic Origi	in? (Spec	ify Yes or N	0- 14	Race -	America	n Indian, Bla	ick,
eath item	uneral	1 X Never Married 2	/arried	Armed Force	s? 2X No	If Ye	es, spec	ify Cuban, I	Mexican,	Puerto Ri	can, etc.)		White, e	etc.		
ter d	ш	3 Widowed 4 D	vorced	f Yes, Give Year	221 NO	1	Yes	2 X No	specify:			Sc	ecifyB1	.ack		
urs al tural	d b	15. Decedent's Education (Sp	ecify only	or Dates: y highest grade c	ompleted)	16a. Decedent		-		ind of wor	k done	16b. Kind	d of Busir	ness/Inc	dustry	-
2 hor	1 2	Elementary/Secondary (0-12		College (1-4 c		during mo	ost of w	orking life. [OO NOT	use retired	1)					
36 hin 7. e. than	omplete	12		,		Janito	or					Faci	lity	Mg	mt	
-00 d wit /gien ther	Į	17. Father's Name (First, Middle	e. Last)			-		18	3.Mother's	s Name (F	irst, Middle,	Maiden Su	rname)			
115 e file al Hy edo	Se C	Vernon Lee Spr	atle	ŠΛ							aunder					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	To B	19a. Informant's Name/Relation				19b. Mailing	Addres						or Town.	State, 7	Zip Code)	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. nt: Ifferen 27 is marked other than "matural", or items 23a or 28a-f should retaining event, the Medical Examiner must be notified at once	-	Frances Saunde		•		1914 V		,							.,	
and 2 and 2 ealth em 2		20a. Method of Disposition	-10 /	TIOCHICE		lace of Disposi					Date				own, State	
of H		1 Burial 2 🔀 Crematic	n 3	Removal from		ematory or oth			· /					-		
Fag Pag ment tant:		4 Donation 5 Other 5	Specify:			timore	Cre	mator	у	07.08	3.2009	Balt	imor	e.	MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important I file are 27 is marked other training verit, the Median and Mental states.		21 Signature of Funeral Salvic	e License	ee		22. N	ame an	d Address of			neral					
⊞ &∆ 5.5			am			1451	7 P	ark H	eiah	ts A	ze Bal	timor	e. M	D_2	1215	
Physician		23. Part I. Enter the disease, of failure. List only one caus	r complic	cations that cause	ed the death.	Do not enter th	e mode	of dying, si	uch as ca	ardiac or re	espiratory a	rest, shock	, or heart	Į.	Approximate Between Or	
/Medica xamine		Immediate Cause (Final diseas		Narcoti	c Into	xicatio	on							- 1	Deat	
Adminio		or condition resulting in death)		ue to (or as a cor										- 11		
	_	Sequentially list conditions,	b											_		
	ie.	if any, leading to immediate cause. Enter Underlying Cause		ue to (or as a cor	nsequence of)	:										
	a E	(Disease or injury that initiated events resulting in death) Last	e -	ue to (or as a cor	nsequence of)	:								-		
cecuted and transit	Exa	Ovolite (Cooking in death) Last	d.													
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760, ficate be ex g physician s the burial	§	IF FEMALE:		23c. If yes, outo	ome of prean	ancv						23d I	Date of de	elivery		
87 tifica ing pl	1	23b. Was decedent pregnant in	the	1 Live birth			al deat	h 3	Ectopic	pregnanc	y		lonth	Da	ıy Y	rear
Box 68: death certiff the attending of for use as s	siciar	past 12 months?		4 Pregnant	at time of dea	th.	ner (Sp					1				
BO e dear the ar	Phys	1 Yes 2 No 9 U	nknown	9 Unknown												
P.O. B s that the d gned by the		Part II. Other significant cond	itions o	contributing to de	ath but not re	sulting in the u	nderiyir	ng cause giv	en in Pa	rt I.	23e. Did	tobacco us	e contribu	ute to th	ne cause of de	eath?
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of Vital Rec ling Physician: The A After this certificate	[2	1 ✓ Yes 2 No	no	spital: 1 🗸 Inpa		ER/Outpatient			-	Nursing i		Residenc		Other:		
Of ing Pl After unera	;	27. Manner of Death		28a. Date of I (Month, Da	njury y,Year)	28b. Time of Ir	njury	28c. Injury		. 1	Bd. Describe	how injury	occurred	t		
ior tend teath tor:	∺	Per	nding estigation	7/1/20	09	unk		1 Ye	s 2 X	No I	ınk					
Division of Vital Records, as after death at Division of Attending Physician: The law requing safet death at Director: After this certificate has been sill of the timeral director, page 2 should be den by the timeral director, page 2 should a] ;ੂੰ	V	uid not be	28e Place of		me, farm, stree	t, facto	ry, office bu	ilding, etc	c. 2	8f. Location	(Street and State) U I	Number	or Rura	al Route Num	ber, City
Div pital or ours afte	Certification:		ermined	(Specify)	unk						OF TOWIT,	State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans				n: To the best of												
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Ex	aminer: (On the basis of earth	xamination an	d/or investigat	ion, in r	ny opinion,	death occ	curred at t	he time, dat	e and place	, and due	e to the	cause(s)	
F 3 F 8	Me	29b. Signature and title of certif		^	Vi -		2	9c. License	number			29d. Da	ite signed	d (Mont	th, Day, Year)	
		1 / 11.1.	Vai	(11)				O.C.M	I.E.			July 3	3, 2009	,		
		30. Name and address of person	D who so	moleted cause a	f death (Item	23a)	L				_					
		Langua La glue MD	A = : = A =	-4 841:1		111 Penn	Stree	et, Baltim	ore, Mi	D 2120	1					
	 State	31. Date filed (Month, Day Year	1	3. Regis	trar's Signator				-,							
Regi	strar	98 67 // (3 1	2009	Chrev	trar's Signar	park										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Firme of Death Month **Physician** Charles J. Schanken 13:35 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City: Jown, or Location of Death Examiner n/a If Under 1 Year 5. Social Security Number Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth **Funeral** 1 ★ M 2 □ F Months Days Hours Min. 6/27/1948 213-52-2324 61 Mary land Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinor must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Taylor Avenue 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No δ Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Sheet Metal Mechanic Constrution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph J. Schanken Mary Ellen Engles ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. Lillian F. Schanken / Wife 1105 Taylor Avenue, Arbutus, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7/9/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate us UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed Yes 2 No prior to completion death? 1 □ Yes 2 🗷 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Talc H

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Baltimore, Maryland 21215-0036

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Records,

of Vital

Division

Caton Avenue

D47353

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21229

and manner stated.

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sigrature

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		Ple	ase Type o								Legible.		
		For State Registrar	State	of Marylan		rtment of H		and M		giene Reg. No.	2009	3 219	12
Physicia /Medic		1. Decedent's Name (First, Mic Charles David							2. Date of De Month	Day		3. Time of Dec	ath //
Examine	2.0	4a. Facility Name (If not institu Augsburg Luth	-			4b. City, Town, or Baltimo	re		4	' I	County of Dea	re	
Funeral Director		5. Social Security Number 236–20–7312	6. Sex 11 M 2□ I	7. Age (In yrs. 1	Yrs.	if Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 3/28/1	nth ay, Year) 921	C	rthplace (State or Fo country) est Virgin	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Usual Residence of Decedent 10a. State 10b. Cour MD Balt	imore		y, Town or Lo							10d. Inside City L 1 ☐ Yes 2	
or 28	Director	10e. Street and Number		45		10f. Zip Code					zen of What C	country?	
eath v	Funeral	6825 Campfie		Apt IB Decedent Ever in U.	S. [13. \	21207 Was Decedent of Hi	spanic Ori	gin? (Spe	ecify Yes or No	USA -	14. Race - Am	erican Indian,	
urs after d al", or Item Examiner	þ	1 □ Never Married 2 □ Never M	Armed 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	f Forces? es 2 ☐ No Give or Dates:		lf Yes, specify Cuba 1 □ Yes 2 🔯 No	n', Mexicar Specify:	ĭ, Puèrto	Rićan, etc.)		Black, Wh	ite, etc. White	
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perm Depa Impo any i		21. Striature of Fulleral Serv	Sin			4107 Wilk						e, Inc. vland 212	227
Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. If immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Mcc	astatic C e to (or as a conseq	ance of):	ter the mode of dyin					by, wa	Approximate interval Betwee Onset and Dea	en ath orths
ficate be executed physician and sthe burial-transit	lical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	5 c	e to (or as a conseq									
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Li 4□P	, outcome pf pregna ive birth 2 ☐ Feta regnant at time of c nknown	al death 3	⊒Ectopic pregnancy ∃Other <i>(specify)</i>					23d. Date of d Month	lelivery Day Ye	ar
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To the Hospital or Attending Physician: within 24 hours after death. To the Furneral Director. After this certifica completely filled in by the funeral director, r.	tion: To	1 Yes 2 No 27. Manner of Death Natural 5 Per 2 Accident	28a. D	l ☐ Inpatient 2☐ Date of Injury Month, Day Year)	28b. Time of Injury	of 28c. Injur	425 111		ome 5 Res 28d. Describe			pecify)	
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To the within to the company of the	Me	29b. Signature and title of cer	tifier			29c. Licens		75	73			nnth, Day, Year)	
		30. Name and address of per	son who completed	pause of death (Iter	n 23a) (Type, M ຊເ <i></i>	Print)	Rei	stev	73 stown	N	10 7	1136	
Sta Registr		31. Date filed (Month, Day, Young)	9 2009	cause of death (Iter	ature 4	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Day **Physician** 2009 14:59 Tucker Annette /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Apt 1413 524 N. Charles Street Balto If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Hours 1 □ M 2 🔀 F Davs Director 216-34-3082 12-28-1936 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 524 N. Charles Street USA 21201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 □Yes 2√XNo Specify Black þ Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) University Hospital permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 Is marked other the any Injury or other traumatic event, Ins. Once. 12th grade <u>Housekeeping</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Tucker Maggie L. Cabiness ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Johnny Powell-Nephew 20a. Method of Disposition 939 Crosswind Place Cockeysville, MD 21030 Date 20c. Location - City or Town, Sta 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 7-9-2009 Baltimore, MD Greenmount 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Beneva 1101 E. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOVASCUCAR DISEASE **Physician** HTPERTENSIVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of: Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CEPEBRO VAS CULAR 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a After this certificate has funeral director, page 2: after death | Director: / d in by the f

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

28a-f show

items 23a or

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the Medical Examiner must be notified at

1 Natural 5 ☐ Pending investigation 2 Accident 3 ☐ Suicide

6 □Could not be determined 4 Homicide

muin

28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

 Location (Street and Number or Rural Route Number, City or Town, State) 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29a. Certifier

3027

29d. Date signed (Month, Day, Year) JULY 08 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

724 MAIDEN CHOICE LAME SUITE ZOY BATTMORE, MO ZIZZZ 5 MILLER 31. Date filed (Month, Day, Year)

State Registrar

Medical



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 1:32 PM M July 3, Patricia R. Tarello 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Jan 19, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 □ M 2 🔽 F 72 124-28-4707 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery 1 ☐ Yes 2 No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11227 Ashley Drive 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) office manager medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Francis Ryan Patricia Theresa Boland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Tarello/spouse 11227 Ashley Drive Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 ☐ Other (Specify) 21. Sign ture of Suneral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street and Baltimore, MD 21201 23a. Part | . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final Pseudomemberanous colitis days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last clostridium difficile infection 5 days Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

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Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or other traumalte event, I'm Modral Examine in all the nothing at any injury or other traumalte event, I'm Modral Examine in all the nothing at

Baltimore, Maryland 21215-0036

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Examine aftending physician and for use as the burial-trar signed by the a certificate has been s rector, page 2 should director, this death. n 24 hours after death.

e Funeral Director: A letely filled in by the fu

Physician: The law requires that the death certificate be executed

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Records,

Division of Vital

or Attending

Hospital

Physician/Medical IF FEMALE: Be Completed by Certification: To

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No pital: 1 Impatient 2 [28a. Date of Injury (Month, Day, Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D 67986

29c. License number

29d. Date signed (Month, Day, Year)

July 3, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Υi

20814 Bethesda MD

31. Date filed (Month, Day, Year) State Registrar

Medical

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JUL 0 9 2009

Yuneng Oswald

Suburban Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** June 30, 2009 :54 PM Gary Twyman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**∑** M 2□ F 212-72-9915 52 June 3, 1957 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "soiled Ext." in round to notified. 1 ☐ Yes 2√ No Montgomery Village Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20137 Welbeck Terrace 20886 USA filed within 72 hours after death Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) nnk 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school system 11 janitorial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Frank Twyman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Harris/sister in law 20137 Welbeck Terrace Montgomery Village, MD 20886 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 MOther (Specify) in state 21. Signature of Euneral S. Licensee Roll S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Mire. Baltimore, MD 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final **Physician** 30 MINUTES disease or condition CARDIAC ARREST ~/Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION 30 MINUTES ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION, HYPERLIPIDEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐Yes 2 ☐No 2 No 1 □Yes 25. Was case referred to medical examiner?

12 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

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32. Registrar's Signature

GOLD

DHMH 17 Rev 1/2001

29c. License number

PRINCE PHILIP DR

D0029300

CLNEY

29d. Date signed (Month, Day, Year)

20832

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ARNESHIA -2009 2 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth's Nursing Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Feb 22, 9. Birthplace (State or Foreign Min. 1 □ M 2 🗓 F Months Days Hours T922 87 Virginia 214-26-6244 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2√□ No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3320 Benson Avenue 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) civilian Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Alter Prease 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Gasdick/daughter 34 Clinton Hill Court Catonsville, MD 21228 of Disposition (Name of Date 20c. Location - City or Town, Stat 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility · Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enjer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Distriction of the condition resulting in death) Approximate Interval Between Onset and Death SEVERAL Due to (or as a consequence of) YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) Year use of death? 4 🔀 Unknown findings available tion of cause of]No

Physician /Medical Examiner

permit. Pages Department of Important: If its any injury or o

Physician

/Medical

Examiner

Director

Completed by Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, I'm Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner and burial-trai the attending physician hed for use as the buria should be detached signed by has been

this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions		, ,	cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death
ESSENTIAL	HYPERTE	MOISH	P	1 ☐ Yes 2[□ No 3 □ Probably 4 ☑ Unkr
	ALZHEIMER UBITUS. RIG			24a. Was an autopsy performed?	24b. Were autopsy findings avail prior to completion of cause death? 1 □Yes 2 □No
25. Was case referred to medical examiner?				ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 🗆 D	OCA Other: 4 Nursing H	Home 5 Residence	S ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	8b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, street, facto	ry, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number,

State

Registrar

Certification: To

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 00018362

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Ste LIO. Baltimore, Md 2/229 K.Dang 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

Дм

Year

2009

USA

Black, White, etc.

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frances Wuiek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Baltmore Franklin Square Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours 215-05-7934 December 28, 1917 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner near be notified at Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2619 Amblen Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2/1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Important: If item 27 Is marked other than any Injury or other traumatic event, In. M. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Joseph Srebroski Alexandra Gogol ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Forsyth 2612 Ambler Road, Dundalk, Maryland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 10, Pages 1 1 Burial 2 Cremation 3 Removal from State Holy Rosary Cemetery 4 □ Donation 5 □ Other (Specify) 2009 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy ď in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) P.0. signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 🗌 Yes Completed peen 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page of Vital 2 PNo 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: Division 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who com ted cause of death (Item 23a) (Type, Print) Nous Binh

20c. Location - City or Town, State Dundalk, Maryland 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Mary Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) quare Drive Baltimore MD **ORIGINAL**

State Registrar 31. Date filed (Month

101

For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Velma C. Walker 200 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner prtal altimore Hand General Hos N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Hours Months Days Min 1 □ M 2√ F 212-30-2746 Virginia 81 Mar 11, 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore 1X Yes 2 No Director Maryland n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 301 McMechen Street - 221 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 **X**If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify \$ Specify. Black 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Sydnor William Sydnor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8221 Chelwynde Avenue Philadelphia, Penn. 19153 Dorothy Sydnor 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Reedville, Virginia 07/20/09 4 Donation 5 Dother (Specify) Shiloh Baptist Church Cemetery 21. Signature of Fundal Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) exitonitis Due to (or as a consequence of preator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse unince of): Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 4 Unknown 1 🗌 Yes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy perforn 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

executed and burial-trar Box 68760, attending physician certificate be the as nse The law requires that the death signed by the atte P.0. Division of Vital Records, icate has been si, page 2 should b certificate Physician: funeral director, this After Attending death. after death Director: completely filled in by the

Funeral

Director

28a-f show

ō

23a

or items

permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam and Jones.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

3 ☐ Suicide

29b. Signature and title of certifier

4 Homicide

29a, Certifier

6 ☐ Could not be

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oacko

and manner stated

Jand General

State Registrar

Medical

32. Registrar's Signature 31. Date filed (Month, Day

Hospital or within 24 hours a

To the Funeral L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** anne June 28, 2009 7:25 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Sunrise of Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Yrs. Sept 6, 145-22-3002 81 Massachusetts Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or iteme 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20850 2264 Glenmore Terrace USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No white Specify If Yes, Give Year or Dates: Specify: Ď 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h Miles Pennybacker ဂ္ Inez Combs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m eny injury or other traum once. 118 Monroe Street #1310 Rockville, MD Raymond Watts/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Vin 21201 Baltimore, MD Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Alzheimers **Physician** years =nd disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ certificate has been signe rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical the funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00061382 07-02-09 nama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shama Ravi Mittal 14816 Physicans Lane Ste 152 Rockville,MD 20850 2. Registrar's Signeture 31. Date filed (Month, Day, Year) State back Registrar 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 123a b per dos 893 a little and Merital Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Charlie Louis Whe1che1 2. Date of Death 3. Time of Death Physician Year 8:00PM Jul 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA ttopital Sinai Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day) **Funeral** Months Days Hours 216.34.3103 GA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Howard Funeral Director Moodstock 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 Harvest Fields Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Insurance Specialist Social Securit 12th grade 17. Father's Name (First, Middle, Last) Z.L. Whelchel tlizabeth Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aurelia N. Whelchel Woodstock MD 21163 10219 Harvest Fields Drive Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Owings Wills, MD Garrison 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee offin C. Greene Funeral sus andalistown 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Orbine dipart e Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Hepatic Failure 5 yrs Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Tes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Willis **Physician** Re 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/14/1960 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🛛 F 48 213-82-1043 Washington D.C. Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No Director Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9944 Canvasback Way 20872 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 1 □Yes 2 No Specify. Specify. Black à 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Donald No1and McRoy Ethe1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9944 Canvasback Way, Damascus, MD Thomas Willis / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Chesapeake Crematory 7/7/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner The law requires that the death certificate be executed

28a-f show

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23a

or items

within 72 hours after

Baltimore, Maryland 21215-0036

and burial-1 attending physician the asn ξ the signed by the detach peen has certificate

P.O. Box 68760,

Division of Vital Records,

Be

Medical

Certification: To

e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral completely filled in by the within 2

> State Registrar

4 Homicide 29a. Certifier (Check only one)

29b. Signature an

3 Suicide

1 ∀es

Varioer of Death

Natural

ccident

2 No

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

and manner stated.

1 Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28c. Injury at Work?

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name a

Hospital:

31. Date filed (Month, Day, Year) JUL 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ZIMMERMA Year **Physician** 0 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Doctor's Community Hospital Prince George Lanham 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 1936 6. Sex Funeral Days Hours Months 1 □ M 2 🔽 F September 14, Washington DC 577-52- 9343 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Exeminer must be notified at 1 √ Yes 2 No Director District Heights Maryland Prince George 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ò 20747 United States items 23a 1505 Wintergreen Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 21 No Specify. Specify: Black ò 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, the Mad DC Public School Elementary/Secondary (0-12) College (1-4or 5+) System Twe1ve Two Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leander A. Brooks Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise Zimmerman/Daughter 7407 Calder Drive, Capitol Heights MD 20743 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 6, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem Clinton, MD 22 Name and Address of FacilityRobert G. Mason Funeral Home Inc 21. Signature of Funeral Service License DAniel W. Harrisonemu 1661 Good Hope Rd SE, Washington DC 20020 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on 11 line. Do not enter the mode of dying, such as cardiac or respiratory arrest, seas Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy requires that the death Year Month Dav in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown 2. Did tobacco use contribute to the cause of death? Part II-Other significant conditions contributing 10 death/but not resulting in the underlying cause Aven in Part I. Division of Vital Records, þ 2**X** No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate has 2 No 1 ☐ Yes 2 No 1 Tes Hospital or Attending Physician: 25. Was ca referred to medical examine?
1 Yes 2 □ No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 40613 and I dress of person who completed cause of death (Item 27a) (Type, Print) NE AU 30 Name 4000 MITCHELEVILLE 21 SUITE 430-1 H.O. registrar's Signature 31. Date-filed (Month, Day, Year) State JUL 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 11:44 PM William Arrono 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death maybral, medical center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) Months Days Hours Min. 1**X** M 2 □ F 583-44-6869 51 10, 1957 Puerto Rico Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Virginia Prince William Woodbridge 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2618 River Basin Lane 22191 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No Specify: Puerto Rican Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Defense 12 Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Genoveva Gelabert Andres Arroyo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2618 River Basin Lane Woodbridge, VA 22191 Wife: Omayra Santos 20b. Place of Disposition (Name of cemetery, crematory or other place)
Covenant Funeral
Service Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 107/06/2009 Fredericksburg, VA 22. Name and Address of Facility Covenant Funeral Service 1310 Courthouse Road, Stafford, VA 22554 23a. Part 🗷 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final multilobe disease or condition resulting in death) Due to (or as a consequence of): of delivery Day Year bute to the cause of death? 3 Probably 4 Unknown Vere autopsy findings available prior to completion of cause of leath?

☐ Yes 2 ☐ No r (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than '

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Department of Health ar
Important: If Item 27 is,
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72 hours after

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran been signed by the should be detached page 2 s has hours after death.

neral Director: After this certificate by filled in by the funeral director, page

Physician/Medical

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Completed

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Certification: To

Medical

2 Accident

4 Homicide

3 Suicide

29a. Certifier

Division of Vital Records, P.O. Box 68760,

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Part II. Other significant conditions of	ontributing to death but not resultin	ng in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	use contri
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25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER	/Outpatient 3 ☐ [OOA Other: 4 I Nursing	Home 5 ☐ Residence	6 □Othe
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Bb. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurre

State Registrar

Jia 31. Date filed (Month, Day, Year)

29b. Signature and title of certifig

6 ☐ Could not be

0.9.200

22

MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours aft

To the Funeral Di

completely filled in

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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31. Date filed (Month, Day, Year)
JUN 2 5 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June **Physician** 2009 24, 0223 Lloyd Lyle Bradford, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**) M 2□ F Months Days Hours Min Yrs. 214-12-4322 87 Director Dec. 25, 1921 Virginia Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 XNo Directo Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 942 Gilbert Road 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\foldapprox \) Yes 2 \(\super \) No If Yès, Give Year or Dates: 1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4or 5+) Locomotive Engineer and Eleven Years Aberdeen, Maryland Crane Operator 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Lyle Bradford, Sr. Margaret Whyte 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Jackson Bradford (wife) 942 Gilbert Road, Aberdeen, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hopewell Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 06/27/09 Port Deposit, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Liger Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** severe preumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performe 1 □Yes 2 □No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

4 IVA Registrar

Pospital or Attending P 24 hours after death. Funeral Director: After t

To the Hospital within 24 hours a To the Funeral D

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 6 2009

Cusur le

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760

Division of Vital Records,

2KAD TO ST

DHMH 17 Rev 1/2001

5015

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0 63420

29d. Date signed (Month, Day, Year)

June 24, 2009

Aue Havrede GRACE, MD 21078

			Pleas	e Type or Prin								
			State of Maryland / Department of Health and N 1 - State People Trans. Certificate of Death					Reg. No. 2000 21025				
		al	Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death 3. Time of 1				
	Physicia /Medic		CECIL BROWNE					JUNE 17	, 2009 Year	0901 A M		
	Examin			4a. Facility Name (If not institution, give street and number) 1297 CHANGELOR POINT RD.			4b. City, Town, or Location of Death					
and the	Funeral				e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	TALBOT 9. Birth	place (State or Foreign ntry)		
П	Director		086-22-2338	82 Yrs.	Months Days	Hours Min.	SEPT.2,	1926	NY			
21215-0036 ed within 72 hours after death with the Maryland	and w	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryl I-f sho		MD TA	LBOT	TRAPP	E			1 □Yes XX No			
	th the		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?		
	s 23a		1297 CHANCELOR			216			USA 14. Race - Ameri	say Indian		
	ter de irern		11. Marital Status 1 ☐ Never Married 2 XX arrie	12. Was Decedent If Armed Forces? d 1 XXes 2 1	ever in U.S. 13.		Hispanic Origin? (Span, Mexican, Puerto	o Rican, etc.)	Black, White,	etc.		
	within 72 hours after death with the Marylan glene. Itan" natural", or items 23a or 28a-f show Ita Medical Examiner must be notified at		3 Widowed 4 Divorced	W II	1 □Yes XX No	Specify:	Specify: WHITE					
	72 hc		15. Decedent's (Specify only highest	16a. Dece (Give	edent's Usual Occup kind of work done	pation during most of work	king	16b. Kind of Business/Industry				
	within iene. than		Elementary/Secondary (0-12)	(Give kind of work done during most of work life. DO NOT use retired) ATTORNEY								
Da.	othe /ent,		17. Father's Name (First, Middle, L.	ast)				ne (First, Middle, M				
Maryi			ROLLIN BROWNE					DOONYA				
	2 s is is		19a. Informant's Name/Relationshi						r, City or Town, State, Zi	p Code)		
	s 1 and of Health item 27 other t		JESSIE BROWNE 20a. Method of Disposition	WIFE	20b. Place of Dispersion Commeterly, cre		APPE, MD		20c. Location - City or T	own, State		
Ē			1 ☐ Burlal XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spi		I		'ION 6-18	8-2009	STEVESNVIL	LE. MD		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of uneral Service	cepsee	2	2 Name and Addre	ess of Facility					
	20 = 2 9		6/11/	1.					NAM FUNERAL N, MD 21601	Approximate		
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America.	Physician /Medical		disease or condition resulting in death)	a. 77/15/	a consequence of):	c CAro	0)1'	years				
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+	od Sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):							
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			/ 1 □ Yes 2 2							2 1No		
	yslcia is cert directo		25. Was case referred to medical examiner? 1 Yes 2 No Hospital;						Residence 6 ☐ Other (Specify)			
Division of	or Attending Physician: after death. Director: After this certific in by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	. Time of lnjury at Work? 28d. Describe how injury occurred						
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	To the H within 24 To the F complete		one) and manner stated.							Date signed (Month, Day, Year)		
	5.≱ 6 8			1///	D31466			6/10/2	6/18/09			
7			30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type				118/0	/		
5	AV+		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ludwig J. Egleseder, II MO 503 Cynwood Or. Easter, MO 21601 31. Date filed (Worth, Day, Year) 32. Registrar's Signature 1. Sauce									
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	ball		,				
	egiəti			JUNIO	p. y							

29a. Certifier (Check only one)

3 Suicide

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUN 2 4 2009

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

460

7.42

32. Registrar's Signature

Funeral Director

Be Completed by

၀

Physician

Examiner

Funeral

Director

/Medical

Register				ertificate d		Mental Hygie	g. No. 2 [100	1 2102	
Registrar Decedent's Name	e (First, Middle	, Last)				2. Date of Death	-	4 4 5	3. Time of Death	
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		, give street and nu		4b. City, Town	vn, or Location of Death		4c. County		1	
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ual Residence of a. State	Decedent 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
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	road S	St.			21769				USA	
Marital Status		12. Was Dec	cedent Ever in U.S. 13			pecify Yes or No-		ice - Amer	rican Indian,	
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3 Widowed		If Yes, Gi Year or D	ive	1 □ Yes 2 X	No Specify:		Specif	ty: Wi	hite	
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(Spec lementary/Secc		st grade completed) College (1-4or 5+) (Giv life.	DO NOT use re	lone during most of wor etired)	iy	fede gover		nt	
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Artn	ur Stı	111			marga	ret Hanı	r1			
a. Informant's N			I		treet and Number or Ru				2 .	
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	□ Cremation	Removal from	20b. Place of Disposer cemetery, cr	position (Name c ematory or other	of rplace) etery 6/2		0c. Location Midd1	-	Town, State Wn , MD	
4 □ Doylation Signature of Fa		- 1								
file	medi Service	1100		POB 18	Middlet .	cown, MD	2176	Hom 9		
Part 1. En er t	he disease, or	complications that only one cause in	caused the death. Do not e	nter the mode of	f dying, such as cardia	c or respiratory arres	st,	- 2-2-1	Approximate Interval Between	
mediate Cause sease or condition	(Final	, say outpg III	prohab	No T	CLD [Tito	ntitial W	na lie		Onset and Death	
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quentially list co any, leading to im- use. Enter Unde	nmediate	Due to	(or as a consequence of).						,	
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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

/Medical Examiner

10 KB

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

66166

2170

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary		tment of F ificate of			ne N2 0 (09 2	1928	
			1. Decedent's Name (First, Middle,	_ast)				2. Dete of Death	Davi		3. Time of Death	
	Physic		Canes	NI 1-X	(,()	1	-	Month	Day	Year	3:200	
	/Medi Exami		4a. Facility Name (If not institution, g	give street end number)	CIII	1	4b. City, Town, or Loc		4c. County	of Death	- 4	
	Lxaiiii	iici	0 0	a Si	_	1	as inch	02	St	Mr.		
			5. Social Security Number 6	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	B Date of Birth	01.	9 Rithplace	40	
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	Director		220-16-7793 Usual Residence of Decedent	8	3		-	1/15/192	25	Maryla	.na	
	and *		10a. State 10b. County	104	c. City, Town or Loca	tion				10d.	Inside City Limits	
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	he N	ec.	Maryland St. N	fary's	Lexing	ton Park						
	£ 9 8	Director	10e. Street end Number			10f. Zip Code		10g.	Citizen of \	What Country?	,	
	238 ath v	<u>a</u>	46401 Kent Driv	7e		206	553		US	5 A		
	de Ser a	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. Wa	s Decedent of H	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-		e - American I		
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02	ours Feb.	b	3 □XWidowed 4 □ Divorced	Year or Dates:	10	1 165 242 140	Specify.		Specify	Blac	:k	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notified at	tec	15. Decedent's (Specify only highest of	Education	16a. Deceder	nt's Usual Occup	ation during most of working	168	. Kind of B	usiness/Indust	ry	
2	u e) de	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	during most or working d)					
7	yiene.	To Be Completed	9	00110g0 (1 101 01)	C	arpenter	c	U	.S. G	overnme	ent	
D	Hygi other		17. Father's Name (First, Middle, Las	; <i>t</i>)			18. Mother's Name (First, Middle, Mai	den Surnan	ne)		
a	Mental Mental arked o		Colbert Barnes, Sr. Iren					e Biscoe				
Maryland	2 should and Men is marked	1	19a. Informant's Name/Relationship		19h Mailing	Address (Street		Rural Route Number, City or Town, State, Zip Code)				
Ma	d2 s than 7 is l	1			E.				•			
	1 and 2 Health Sem 27 i		_ David Barnes/So		4040 I Ob. Place of Dispositi		rive, Lexi					
Ö	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition 13☐PBurial 2 ☐ Cremation 3		cemetery, cremat	tory or other plac	(e)	Date 200	. Location -	City or Town,	State	
<u>=</u>	× = = ×		4 ☐ Donation 5 ☐ Other (Spec		St. Peter	Claver	6/	27/09 S	t. In	igoes,	MD	
Baltimore,	permit. Par Department Important: any Injury once.		21. Signature of Funeral Service Lic	ensee Ma	22. N	ame and Addres	ss of Facility Brin	sfield F	unera	1 Home	. P.A.	
m	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		21. Signature of Funeral Service Licensee Shawn Aylesworth M01521 22. Name and Address of Facility Brinsfield Funeral Home, P.A 22955 Hollywood Rd., Leonardtown, MD 20650									
		2 10	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Open and Posth									
	Physician / /Medical		Immediate Cause (Final disease or condition Devector A Pears									
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н		Examiner	resulting in death) a. Pue to (or as a consequence of):									
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	and tran	Eam	Sequentially list conditions,	Due	to (or as a conseque	nce of):					0	
68760,	micete be executed g physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	blass	20140	2110	an an			14	eans	
176		edical	Cause (Disease or injury that initiated events									
89			resulting in death) Last		1							
Box	The law requires thet the death certi ate has been signed by the attending page 2 should be detached for use a	Ş		l J						1		
m	leath atte	by Physician/M	Dort II. Other circuitionet conditions	1.0	F and mark 173							
P.O.	ned by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cau			cause of death?	
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ta			25. Was case referred to medical	1			OS Place of Death (
of Vital	nysician: nis certifica I director, I	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0 C 5 D (O) 15 - 11 - 1	Othe	26. Place of Death (· · · · · · · · · · · · · · · · · · ·		
ō	Physician: this certific ral director,	Certification: To	27. Menner of Death	1 inpatient 2 in EH/Outpatient 3 in DOA 42 Nursing Home 5 in Residence 6 in Other (Specify)								
Division	After fune		Natural 5 ☐ Pending	(Month, Day Yea	(Month, Day Year) Injury Work?				25d. Bosonbe now injury occurred			
Si.	Attending I or death. ector: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	he			Yes 2 □ No	() ()				
₹	or Al	ŧ	4 Homicide determine	28e. Place of Injury - A building, etc. (Sp		, factory, office	28	f. Location (Stree City or Town, S		er or Rurel Ro	ute Number,	
			A									
	Hospital 24 hours Funeral I	edical	29a. Certifier Certifying P	hysician: To the best of my miner: On the basis of exam	knowledge, death or	curred at the tim	e, date and place, and	due to the cause	e(s) and ma	nner as stated	d.	
	he H	8	one)	and manner stated.	milation entroi invest	uganon, mmy op	Jinion, Geath Occurred	at the time, date	anu place, e	eria ane to the	Gause(s)	
	To the	Σ	29b. Signature and title of certifier	100-	1	29c. License	number			d (Month, Day,		
	10		D. IT, A	Halal.	a. W	1) 4	604	0 4	0_2	25-2	2009	
-4	A .		30. Name and address of person who	completed cause of death	(Item 23a) (Type Prin	21)					,	
1	2				(III 236) (Type, Prir	•	late Mes-	1004 204	1.6			
			Amir N. Alik 31. Date filed (Month, Day, Year)	nani, M.D. 32. Registrar's S	ignature -	Lar	lata, Mary	Taild 200	140			
	Sta	te	LIN OO	anno 32. Fagistrar's S	Igilatule 1	- a 1						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 8:50 P M Violet Mae Boyer 2009 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death omic HOSDICE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🕱 F 217-12-2012 86 04/05/1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Maryland Wicomico Fruitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 706 W. Main St. 21826 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emily Adaline Hildebrand Oscar Clarence Schultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 706 W. Main St., Fruitland, MD 21826 Kathryn Dykes/daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/09 Parsons Cemetery Salisbury, MD 4 Donation 5 DOther (Specify) ervice Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Immediate Cause (Final disease or condition resulting in death) Kenal 2023 Due to (or as a consequence Sequentially list conditions, if any, loading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 Mo 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospic 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

Physician /Medical Examiner executed

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

Be

ital Hygiene. 2d other than "natural", or Items 23a or 28a-f shov event, if a Medical Evantor must be notified at

Health and Mental Hygi em 27 is marked other

permit, Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau

or other traumatic

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

sician and burial-transit this certificate has been signed by the attending physician al director, page 2 should be detached for use as the buria To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

Completed

Be

ဥ

Certification:

Medical

Box 68760,

P.0.

Division of Vital Records,

Attending Physician;

the death certificate be

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No

1 Yes 2 No

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work?

1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

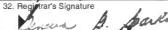
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

-22-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERBY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jul 1, 2009 **Physician** 7:20 A M Louise Barton Wanda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Devlin Manor Nursing Home Cumberland Date of Birth Month, Day, Mar 1, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1922 Months Days Hours 1 □ M 2 □**X*** ΜD 212-18-1948 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa direct must be notified at MD Allegany Cumberland 1 ☐XYes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 133 Race Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify. Completed by white 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Alberta Ruth Kelly Lease Mason Burr Lease ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 5335 Cresaptown MD 21502 19a. Informant's Name/Relationship (Type. Print) Kelly Ridgeway P.O. Box 5335 daughter Cresaptown 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 7/3/2009 MD LaVale 4 ☐ Donation → ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Linnsee 23a. Part1. Enter the disease, or/complications if at daused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line.

Immediate Cause (Fire disease or condition resulting in death)

a. Cause of the disease of the disease of condition resulting in death) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Betwee Onset and Dea **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 No 9 Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has in inector, page 2 st autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗐 🗐 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1-X Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be

Box 68760, P.0. Division of Vital Records, bspital or Attending Physician: hours after death.

Ineral Director; After this certifical by filled in by the funeral director, p To the Hospital within 24 hours a To the Funeral C completely filled

Baltimore, Maryland 21215-0036

State Registrar

Medical

3 🗌 Suicide

29a. Certifier

4 - Homicide

(Check only one)

31. Date filed (Month,

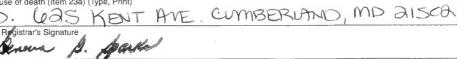
29b. Signature and title of

dertife

M.D. leas GUPTA 32. Registrar's Signature 0 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00033280

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Blubaugh 2009 03 Homer S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY COMBGRIAND MEMORIAL HOSPITAL Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Jun 3, 1937 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₩ M 2□ F Months Days Hours MD 214-36-7012 72 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show MD Allegany Oldtown 1 ☐Yes 2 ☑ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19707 Oliver Beltz Road 21555 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify. þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Allegany Co. Bd. of Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur F. Blubaugh Margaret L. (Weese) Blubaugh ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19707 Oliver Beltz Road Oldtown MD 21555 19a. Informant's Name/Relationship (Type. Print) wife Jean Blubaugh 20b. Place of Disposition (Name of cemetery, crematory or other place)
SS Peter and Paul Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/6/2009 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility al Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or hear/failure. Unit only one cause on each line. Immediate Cause Final disease or condition resulting in death **Physician** mo 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performe 2 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√0 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA ٩ this eral Director; After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D36766 6 , 200 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

DX

State Registrar VIK POONAI

31. Date filed (Month, Day, Year)

M.D

924 SETON DR

Registrar's Signature

COMBERLAND, MD

21502

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend #25, 27, & 28a-1, perME, g893 7/15709 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 22, 2009 2000 Shirley Easterday Crouse June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (Month, Day, Year) June 22, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** New York Days Hours Months 219-28-1477 1 □ M 💢 🖫 F 78 Yrs 1931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes XXNo Director Maryland Cecil Port Deposit 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21904 U.S.A. 33 Abrahams Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2**¥**∑No Specify. If Yes, Give Year or Dates: Specify: Be Completed by White 3 ☑ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harford Memorial Two Years Elementary/Secondary (0-12) Hospital L.P.N. Havre de Grace. es 1 and 2 should be filed v of Health and Mental Hygie f item 27 is marked other t ir other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Easterday Thelma Paxton ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a Sandra Crouse Heathcott 309 Guilford Court, Bel Air, Maryland 20a. Method of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ö Department of Important; If any injury or once, 06/28/09 Hopewell Cemetery Port Deposit, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903-0766 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory argest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** for Dr. M. Ripple /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) as IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 Other (specify) 9 Unknown 9 I Inknown detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No Physician: The 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 22 No 1 phopatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 5 ☐ Pending investigation multiple falls Natural Natural 1 ☐ Yes 2 No 2 X Accident unk unk after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office **unk**uilding, etc. (Specify) 28f. Location (Street and Nymber of Bural Route Number ions City or Town, State) Multiple Locations completely filled in by determined 4 Homicide 6 Unknown addresses, MD To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) SONNO Mont 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 26 2009 Registrar

DHMH 17 Rev 1/2001

2

Please Type or Print in Black Indelible Ink, 5 hsure All Copies Are Legible.

Amend Item 12 per FH (893) Ink, 5 hsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 WINFIELD July HENRY COCHRAN JR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice Care 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 215-36-8274 70 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏠 No Director MD. Monkton Harford 10g. Citizen of What Country? 10e Street and Number 10f Zin Code United States 21111 3611 Jarrettsville Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 2 Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Machinery Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfield Cochran Sr. Matilda ပ္ Henry Werneke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 205 W. High St. Elizabethtown, PA. 17022 Steven W. Cochran Sr./Son 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 7/7/2009 Hampstead, Maryland Cremation 22. Name and Address of Facility E.G. Kurtz & Son Funeral lodden Jarrettsville, Maryland Home, P.A. Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip. Immediate Cause (Final **Physician** Ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Be Completed Medical Certification: To

executed burial-trar Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be as the Se ؤ ed by the signed I page 2 completely filled in by the funeral director, this within 24 hours after death. To the Funeral Director; A

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Evaninar must be notified at

7 is marked other traumatic event,

Pages 1 and 2 should be facent of Health and Mental

						24a. Was an autopsy performed? 1 □Yes 2 ☑No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	T				26. Place of Dea	th (Check only one)	. 1
examiner? 1 ☐ Yes 2 ☐ No	Н	ospital: 1 🗋 Inpatient 2 🗆	ER/Outpatient	3 🗆	DOA Other: 4 Nursing H	lome 5 ☐ Residence 6	Other (Specify + USPIC
27. Manner of Death 1. ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28e. Place of Injury - At he building, etc. (Special	ome, farm, street	t, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,

29b. Signature and title of certifier

Date filed (Month, Day,

29a. Certifier

25105

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

and manner stated.

N. Charles St. Balto. Md 2: 20 8

State Registrar

ORIGINAL

		For State Registrar	State	of Marylar		artment of l rtificate of		nd Mental H	ygienę Reg. No	211119	21934
Dhyo	ioion	1. Decedent's Name (First, Middl	e, Last)					2. Date of I	Death Day	y Year	3. Time of Death
Phys /Me	dical	VALERIA W. DOR	-					JUNE	17, 2	009	10:00 P M
Exan	niner	4a. Facility Name (If not institution				4b. City, Town, o		Death		. County of Death	
Farmer		KENSINGTON NURS 5. Social Security Number	SING & RE.	HABILITA 7. Age (In yrs.		KENSIN If Under 1 Year	GTON If Under 24	Hrs. 8. Date of E		ONTGOMER 9. Birth	Y place (State or Foreign intry)
Funer Directo		579-20-9931	1□ M 2፟፟፟XF	84		Months Days	Hours	Hrs. 8. Date of E (Month, 1)	Day, Year) 1925	Wasl	intry)
pu ,		Usual Residence of Decedent		J							
arylar show	7	10a. State 10b. County			ty, Town or Lo						10d. Inside City Limits 1XXYes 2 □ No
the M 28a-f	ect	DC 10e. Street and Number		Was	shingto	n 10f. Zip Code			10g Cit	tizen of What Cou	
aa or	Funeral Director	1918 Savannah E	Diago CE			2002	0			ed State	,
death	nera	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin	n? (Specify Yes or I		14. Race - Amer	ican Indian,
after or ite	F.	1 ☐ Never Married 2 ☐ Marr	ied Armed F 1 □Yes If Yes, G	2 🔼 No		ryes, specily Cub I∐Yes 2 X No	Specify:	Puerto Rican, etc.)		Black, White,	
hours a	Ş Q		Year or	Dates:						Specify: B1a	
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I be filed intal Hyg ed othe event,	Be C	17. Father's Name (First, Middle,	Last)				1	Name (First, Mida			
at y lattic Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland mod Mertal Hygiene. In after do ther than "natural", or items 23a or 28a-f show umatic event, the Medical Event has notified at unatic event, the Medical Event has a notified at	5 B	Clarence I. Wes	st				Ruth	Johnson			
0 00 0		19a. Informant's Name/Relations	hip (Type. Print)			,		or Rural Route Nun	. ,		,
1 and 2 Health Hem 27 in		Deide E. Point 20a. Method of Disposition	/ Daught					SE Washi		n , D.C.	
Dalliniole, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		1 X Burial 2 ☐ Cremation		n State	-	sition (Name of natory or other pla					
Dallillo Dermit. Pages Department or mportant: If it	oi	4 □ Donation 5 □ Other (S	11	Mt	. Olive			24/2009 Ope Funer		hington,	
permit. Departrimporta	once	Kint O	Lune	M010	5-5 B G 1			e Forestv			
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Physicia	n 🗎	Immediate Cause (Final disease or condition			le roti	c Car	diova	es cular	Dicon	a Se	Onset and Death Unknow w
/Medica	_	resulting in death)		o (or as a conseq		- 04.			7130		
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exection and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to	o (or as a conseq	juence of):						
icate be executed physician and the burial-transit	dical		d								
ortificat ing phy	- w	IF FEMALE:	I						-1		-
res that the death certification by the attending be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Feta	al death 3	Ectopic pregnan	су		0.7	23d. Date of deli	very Day Year
the a	ysic	1 □ Yes 2 No 9 □ Unknown	4 ∐ Pre 9 □ Unk	gnant at time of a known	death 5	Other (specify) _		-		mona.	Day Tour
that the the by detac		Part II. Other significant condities	s contributing to	death but not res	sulting in the ur	nderlying cause gi	ven in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?
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aw rec	olete	Hu pert	-unsi on	,	,			24a. Wa			opsy findings available
The la	Completed								topsy rformed? 2 A No	death?	ompletion of cause of
ctor, p	Be	25. Was case referred to medical examiner?					26. Place of	f Death (Check only		7 12100	
hysia this c	ုင	1 □ Yes 2 No			ER/Outpatier	I S D DCA		ing Home 5 ☐ Re			ify)
After funera	ion:	27. Manner of Death 1 Natural 5 □ Pendin	g (Mo	e of Injury nth, Day, Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2.∐No	28d. Describ	e how inju	ry occurred	
Attended death death ctor:	ficat	2 Accident investig 3 Suicide 6 Could i	act be	e of Injury - At he	ome, farm, str		Tes ZLINO		(Street ar	nd Number or Ru	ral Route Number,
alor after dinb	Certification:	4 ☐ Homicide determ	med build	ding, etc. (Special	fy)	eet, factory, office		City or 7	own, State	e)	
To the Hospital or Attending Physician: The law requires that the death certifications after destine certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as								place, and due to t			
the Ho lin 24 the Fu	edical	(Check only 2 Medical one)		nner stated.	ation and/or in	vestigation, in my	opinion, death	occurred at the tim	e, date an	d place, and due	to the cause(s)
Naith Son	Σ	29b. Signature and title of certifier				29c. Licen:	se number	,	29d. Da	ate signed (Month	, Day, Year)
		Ch	as dry	,		1	43/21	1		0/19/2	.007
5		30. Name and address of person	who completed cau	use of death (Iter	m 23a) (Type, I	Print)	1 700111	F: Bun	TONIC	VILLE.	MD20866
9	State	NURUL CHO 31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature ,	יווע שוי	ZKIV	U / /94 PC	(0,0)	- 1 /	
Regis		JUN 2 6 2009	Reserve	N A	GRIKA)	•					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 JUNE 19. **Physician** BARBARA R. DRYDEN 2:42 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** MARCH 1, Yel 935 Months Days Hours Min. OHTO 1 □ M 2 🖫 F 74 234-54-4515 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantarian must be rutilled at 1X Yes 2 □ No Director TALBOT EASTON MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21601 AVE. 707 ELWOOD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER ENGLISH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE MOORE FRANCIS H. ROLLYSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 707 ELWOOD AVE. EASTON, MD 21601 ROBERT T. DRYDEN / HUSBAND 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 6-21-09 STEVENSVILLE, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonta **Physician** seeks /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mor law requires that the death certificate be executed Due to (or as a consequence of) -burial-Division of Vital Records, P.O. Box 68760, attending physician for use as the burian Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) the 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part Jl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform he certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

12

Registrar

State

nari 31. Date filed (Month, Day, Year) **JUN 22**

Challano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles St 6701

D 209 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 3:58 P M Winfield Scott 06 18 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner RAUMA enter 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Davs 1**XX**M 2□ F 217-24-9541 MD 80 MAR 27, 1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "worthal Exercises", ust be notified a once. XXYes 2 No Director TALBOT ROYAL OAK 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 4661 DEVON PATH 21662 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □Yes 2XXNo tf Yes, Give Year or Dates KOR WAR Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) URBAN DEVELOPMENT VICE PRESIDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WINFIELD SCOTT DITCH, JR MARY LAMB SMITH ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOANNE DITCH 4661 DEVON PATH ROYAL OAK, MD 21662 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-22-2009 LOUDON PARK CEMETERY BALTIMORE, MD 22. Name and Address of Eacility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 days Seplic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last NO ST PERM EN P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 ☐ Ectopic pregnant 5 ☐ Other (sp 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Day Vear I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anzmia autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 res 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A death. Standing 2 Accident 3-2009 MEHOM Prfell From 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4661 DEVOR Path 4 Homicide MD Oak within 24 hours a Home ROUAL Hospital LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifief 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar S Green

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Registrar's Signatu

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

J. 5

JOHN

31. Date filed (Mont)

			For State Registrar	State of Mary		ertificate of			eg. No.2 0 0 9	21937
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		John Dennis Dea	an Jr.				June 26		9:15 a.m.
	Examin		4a. Facility Name (If not institution, give str				r Location of Death		4c. County of Dea	
				26930 Three Notch Rd. Mechanicsville St. Mary						
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry) Maryland
	Director		Usual Residence of Decedent		J			rebluar	y 3,1994	riaryrand
	yland now		10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Limits
	a-fst	ctor	Maryland St. Mary	¹s	Mechani	csville				1 □Yes 2X No
	or 28	Directo	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	ountry?
	23a	ral	26930 Three Notch			20659			USA	
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, I'm Modical Eventiand it and by notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: 1	1953 18	 Was Decedent of Harden of	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
2-003b	hour tural		15. Decedent's Educa		16a. Dec	cedent's Usual Occu	pation		16b. Kind of Business	/Industry
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7	d with giene ar tha	Completed	12	College (1-401 3+)	Mot	orcycle Po	olice		Depar	tment
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ylan	Ment Ment arkec aric e	P	John Dennis Dean					te Walla		
Mar	2 sho and is m raum		19a. Informant's Name/Relationship (Type	e. Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Number	r, City or Town, State,	Zip Code)
es Os	l and lealth sm 27 sm 27 sher t		Jean C. Dean/Wife			30 Three I position (Name of			icsville, 20c. Location - City or	
ב פ	t of the state of		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Rer	moval from State	cemetery, c	ematory or other pla 1d-Echo1s	^{ce)} ∶Tur	12069,	•	e Hall, MD
апп	iit. Pa urtmei rtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign in of Fuheral Service Licensee					1	-Echols F.	-
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the fun	Medical (29a. Certifier 1 Certifying Physi (Check only one)		amination and/o				cause(s) and manner date and place, and du	
	ithin (and manner stated. 29c. License number 29d. Date signed (Month, Day, Y								nth, Day, Year)
•	^X	D0028544 June 29, 2009							2009	
	α		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	K-		Colleen Jude, M.D.	Leonardt	own. Ma	rvland 2	0650			
	Sta		31. Date filed (Month, Day, Year) 200	9 32. Registrar's	Signature	hads				
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Please Type or Print in Black Indelible Ink. 3505 ure All Copies Are Legible.

Amend Item 20b per FH 6893

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:08 a.m. **Physician** June 20, 2009 Dyson Dupuis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Great Mills 45861 Mountain Laurel Way Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1♥ M 2□ F Connecticut 09/02/1922 Director 100-12-1189 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a State show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2X No Director Great Mills Maryland |St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20634 45861 Mountain Laurel Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify: Specify: Baltimore, Maryland 21215-0036 White 2 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Radar Electronics Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lighty or other traumatic event any lights. 17. Father's Name (First, Middle, Last) Be Marion Adelaide Morgan Clyde Edwin Dupuis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18707 Drummond Place, Leesburg, VA Mark Dupuis/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 6/29/2009 Charlotte Hall, MD Brinsfield-Echols Cre 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road, Leonardtown, MD 20650 Shawn Aylesworth MO1521 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to Thrive /Medical Due to (or as a consequence of) Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectonic/pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No the g Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. 2 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 **X**No 1 ☐ Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one) Physician; 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 ី Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this Certification: To of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Attending 5 Pending investigation Division 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident by the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 0 To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gentifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number (40055751 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane, Leonardtown, MD 20650 Jennifer Schmidt, D.O. 31. Date filed (Month 10) 29 2009 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** Davis Ramona Mae 07 03 2009 1500 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY WMHS-BRADDOCK CAMPUS Date of Birth (Month, Day, Jul 28, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 M 2 □ ₹ Months Director 213-12**-**9487 91 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene.

ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evarities roughts to motified at MD Allegany Cumberland 1 □Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 901 Seton Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: ò Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Memorial Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Grace Reeder Arnsley B. Reeder ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt 1 Rox 274 Ridgelev WV 26753 19a. Informant's Name/Relationship (Type. Print) Rt. 1 Box 274 Ridgeley Charlotte McCullough daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any injury or o 1 Burial 2 □ Cremation 3 □ Removat from State **Davis Memorial Cemetery** 7/7/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funer Service License 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complice lons/that I used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lach line. Immediate Caus- (Final disease or condition resulting in dea.) V **Physician** Nosocomia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifted in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) □Yes 2No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar autopsy performed' 1 ☐Yes 2 KNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grantsville MD 21536 265 AWAD AbAhat 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 June 23, 5:35 AM James Vincent Fortuna 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4024 Jeffry Street Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Months Days Hours 1 X M 2 □ F 236-26-1375 July 12, 1925 | West Virginia 83 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 4024 Jeffry Street 12. Was Decedent Ever in U.S. Armed Forces? 1 M2 Yes 2 □ No If Yes, Give Year or Dates: 1042-6 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 1942-64 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Navy 12 Lithographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Fortuna Mary Leggato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10428 Brookmoor Drive Silver Spring, MD 20901 G.P. Fortuna/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 06/24/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Going Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmea? 2•1⊆No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

10a State

Examiner

Funeral

Director

28a-f show

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If Item 27 is marked other than or other traumatic event.

Department of H Important: If Ite any injury or otl once.

event, the Medical Examiner must be notified at

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria been signed by the should be detached

Examiner Physician/Medical \$ Completed 24 hours after death.

Funeral Director: After this certificate has etely filled in by the funeral director, page 2 s Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the within To the compl	
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐Yes 2⊠No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

> 29c. License number MO 040668E (PA)

29d. Date signed (Month, Day, Year)

June 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burnstern,

8901 Wisconsin AVE Bethesda, MD 20889

barks

29b. Signature and title of certifier

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercities that the natified at gonge. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Physician

Examiner

/Medical

Physician /Medical Examiner

attending physician for use as the buria

Division of Vital Records, P.O. Box 68760,

Director	Md.	Prince Ge	orge's	Lank	nam				1 Yes 2 No		
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Funeral	11. Marital Status		12. Was Decedent 8 Armed Forces?		13. Was Decedent of If Yes, specify C	f Hispanic Origin? Jban, Mexican, Po	? (Specify Yes or No uerto Rican, etc.)	14. Race - Ame Black, White			
by F	1 ☐ Never Marı 3 ☐ Widowed	ried 2 Married 4 Divorced	1 ∐Yes 2 ≹ 1N If Yes, Give Year or Dates:	No	1⊡Yes 2x⊡N		,		Specify: Black		
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ge C		(First, Middle, Last)				18. Mother's I	Name (First, Middle	, Maiden Surname)			
2	Charles Thomas Sarah Jackson										
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
	Sherile	Fletcher/	Daughter		7916 Cawke		anham,Mar				
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		5 Other (Specify)		Mt. Ol	ivet Cem.	07,	/01/09	Washington	D.C.		
1	21. Signature of Fi	uneral Service Licens	- AP ()	-	22. Name and Ad H.S. Wa	ress of Facility Shingtor	n & Sons (Co.,Inc.			
			M. Sr.	all	4925 Burn	oughs Av	ve.,N.E.,	Washington,			
	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately										
	Immediate Cause		Onset and Death								
	disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of):										
<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Systemic Acidosis Due to (or as a consequence of):										
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sicia	in the past 12 1 ☐ Yes 2 1	¥No	4 ☐ Pregnant at		5 ☐ Other (specify)			Month	Day Year		
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<u>۲</u>	1 Yes 2 ☐ 27. Manner of Deat	140	1 Inpatie		patient 3 100A			dence 6 ☐ Other (Spe	cify)		
ţ	1 🔀 Natura!	5 Pending investigation	(Month, Day	(Year)	jury W		280. Describe	how injury occurred			
tifica	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju building, etc					Street and Number or Ro wn, State)	ural Route Number,		
8		-41					1014		<u></u>		
Medical Certification: To	29a. Certifier (Check only one)	1 I Certifying Phy 2 Medical Exami	rsician: To the best of iner: On the basis of and manner sta	examination and	death occurred at the l/or investigation, in m	time, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)		
Me	29b. Signature an	title of certifier				nse number		29d. Date signed (Mont			
) //	11/11/	-1X60	- W	D39	061		June 23,200)9		

State

Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mitchell N. Ross, M.D.

31. Date filed (Month, Day, Year)

JUN 2 6 2009

М

1-	For State Registrar
	Registrar

te of Maryland / Department of Health and Menta	al Hygiene
Certificate of Death	Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) MARRINER GRAY AFFIE

Reg. No.

2. Date Mont 6/

of Death		3. Time of De	eath
23/2009	Year	0430	a

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

er	4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Death				4c. County of Death			
	FT. WASHINGTON H			FT. WASHINGTON If Under 1 Year If Under 24 Hrs. 8, Date of Birth				PRINCE GEORGES		
	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) _ Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da NOV • 18	h y, <i>Year)</i>	C ~ 1	nplace (State or Foreign Intry) CAROLINA	
	Usual Residence of Decedent	74	113.			NOV. 18	,1934	NOKI	H CAROLINA	
	10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits	
ō	MD PRINCE GEORGES	FT.	WASHING	GTON					1 □Yes 2 🕱 No	
ect	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cou	Intry?		
급					77.7					
eral	8605 ALLENTOWN ROAD	cedent Ever in U.S	2 12 14		744	pacify Vas or No.	USA		rican Indian,	
ä	Armed F	orces?	If	Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Bia	ack, White		
by	3 Widowed 4 Divorced Year or	aive	1	□Yes 2 X No	Specify:		Speci	ify: W	HITE	
eq	15. Decedent's Education		16a. Decede	edent's Usual Occupation 1				6b. Kind of Business/Industry		
plet	(Specify only highest grade completed	(Give k life. D	ind of work done O NOT use retire	during most of world)	king		,			
Be Completed by Funeral Director	Elementary/Secondary (0-12) College	(1-4or 5+)	Н	HOUSEWIFE				Œ		
e C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	ime)		
고 B	JULIUS JEFFERSON MARRIN	ER			VIOLA TR	RUEBLOOD				
-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Town	n, State, Z	ip Code)	
	AIMEE GRAY / DAUGHTER		520 G	OLDENROD	TERRACE,	WESTMI	NSTER, M	D. 2	1157	
	20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of atory or other pla	ce)	Date	20c. Location	- City or T	Town, State	
	MXxBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CEDARWOOD CEMETERY 7/2/2009 roanoke rapids, NC.									
	21. Signature of Fulleryl Service Licensee 22. Name and Address of Facility 811 Cameron Street									
	Cunningham Funeral Home Alexandria, Va. 22314									
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Immediate Cause (Final Onset and Death									
	disease or condition resulting in death) Due to	o (or as a consequ	rence of):	2.4	v 110095	ca lan	0,00	45		
		OU	grica	1 Can	rcev					
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequ	uence of):							
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events c									
Ex	resulting in death) Last Due to	o (or as a consequ	uence of):							
Physician/Medical Examiner	d									
led	I F F F F F F F F F F F F F F F F F F F									
N.	23b. Was decedent pregnant	utcome of pregna e birth 2 🗆 Fetal		Ectopic pregnance	27			ate of deli		
sicis	1 Yes 2 No 4 Pre	gnant at time of d		Other (specify) _			,	M onth	Day Year	
hys	9 ☐ Unknown	NIOWII								
	Part II. Other significant conditions contributing to		ulting in the un-	derlying cause giv	en in Part I.	23e. Did to			the cause of death?	
ed	a chemothe	rgv				10	Yes 2 No	3∏ Pr	obably 4 Unknown	
plet						24a. Was		. Were au	topsy findings available completion of cause of	
E	{	-				perfo	rmed?	death?	LA	
Se C	25. Was case referred to medical				26. Place of Dea					
0	examiner? 1 Yes 2 No Hospital: 1 E	Inpatient 2	EB/Outpatient	1 3 □ DOA Oth	ner: 4 Nursing H	lome 5 Resid	dence 6 □0	ther (Spec	oify)	
Ë		e of Injury onth, Day, Year)	28b. Time of Injury	28c. Inju Woi	ry at	28d. Describe I	how injury occu	urred		
atic	2 Accident investigation	man, Bay, roar,	,,		Yes 2□No					
tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plac	ce of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S		nber or Ru	ıral Route Number,	
Cer										
25. Was case referred to medical examiner? 1					ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and place	manner as e, and due	s stated. to the cause(s)	
Mec	29b. Signature and title of certifier	29c. Licens	se number		29d. Date sign	ned (Monti	h, Day, Year)			
	Millow	D0046	5947		6/26/2	009				
	20. Name and address of corner who complete	upp of don't /lt-	22a) /T F		,,,,,		5,25,2			
	30. Name and address of person who completed ca Michael Granovsky, M	/			ad, Ft. W	ashingto	on, MD.	2074	14	
te	31. Date filed (Month, Day, Year) 32	Registrar's Signa	ture /	4/	,		, , , , ,			
ar	JUL 0 9 2009 /2	Registrar's Signa	9. Apa	No.						

State Registrar

State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiand	•	rtificate of I	leaith and iv Death		Reg. No		2101.2	
	Dhi.i.i		Decedent's Name (First, Middle, La	st)					2. Date of De	ath Da	Year	3 Time of Death	
	Physicia /Medic	al	Steven Giannas						June 1	9, ^{Da}		5:20 A M	
e	Examin	er	4a. Facility Name (If not institution, giv 11793 Thomas Spri	· ·			Monrovia	Location of Death			County of Death		
Page	Funeral Director		119-46-7462	Sex 7. Age	(In yrs. las	t <i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 11	y, Year	9. Birthp Coun 955 Gree		
	/land ow at	H	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation				1	0d. Inside City Limits	
	e Mary la-f sh tiffed	ctor	MD Frederic	k	Monr	ovia						1 □ Yes 2 No	
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 11793 Thomas Spri	ng Road			10f. Zip Code 21770			USA	tizen of What Coun		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))·	14. Race - Americ Black, White, Specify: Whi	etc.	
21215-0036	72 ho "natur dical I	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usual Occup	ation during most of work d)	ing	16b. K	(ind of Business/Ind	dustry	
121	within iene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		ct Manage			Sof	ftware		
pu	a filed at Hyg other	Be C	17. Father's Name (First, Middle, Last	•				18. Mother's Nam			n Surname)		
ylaı	2 should b and Ment Is marked raumatic e	10	John Giannakopoul		405 Maille	Add (C44	Anna Kar			er Teure State Zin	Code		
Maryland	and 2 sho ealth and n 27 Is mi er traumi		19a. Informant's Name/Relationship (Ruth P. Giannas/v				-	and Number or Rui Spring Ro					
	es 1 and 3 of Health f Item 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		20b. Plac	ce of Disponetery, crei	sition (Name of matory or other plac	ce)	Date	20c. L	ocation - City or To	own, State	
Baltimore,	t. Pages tment of I tant; If Ite		4 ☐ Donation 5 ☐ Other (Speci	fy)	Fina			natory 06					
Ba	permit. Departr Imports any Inju	Į.	21. Signature of Funeral Service Lice	Hall H	/ MO125			*Crematio				, MD 21029	
	<u>\$</u>		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin								Approximate Interval Between	
-	Physician	i	Immediate Cause (Final disease or condition	a. metas	statio	- lu		ncer				Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):)	V110000 1.47 11					
	- 4 	ner	Sequentially list conditions,	b. Due to (or as	a conseque	nce of):							
	ecutec and -transii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of):								
68760,	ificate be executed g physician and as the burlal-transit	ai E		Due to (or as	a conseque	nice ory.							
_	fificate ng phys as the	Medical		G									
P.O. Box	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy nant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day Year		
	s that t ned by e detac	by Ph	Part II. Other significant conditions	contributing to death be	ut not resulti	ing in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?	
Division or Vital Records,	equire een sig ould b	ted b							1 🗆	Yes 2	No 3 Pro	bably 4 □Unknown	
Sec	The law interpretate has be based as a sage 2 sh	Completed			·				24a. Wa auto per	opsv	prior to co	opsy findings available empletion of cause of	
Ta F			25. Was case referred to medical					26. Place of Dea		2 N	lo 1 ☐ Yes	2 No	
Z	> 0 0	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 El	R/Outpatie	nt 3 DOA Oth		1 .		6 □Other (Speci	fy)	
0 UC	After th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Year) 2	8b. Time o	Wo	ryat rk?]Yes 2 ∐No	28d. Describe	how inj	ury occurred		
/isio	Attending r death. ector: After by the funer	ficati	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of inju		ie, farm, st	reet, factory, office	Tes ZINO			and Number or Rur	al Route Number,	
á	tal or safter al Dire	Certification:	4 ☐ Homicide determined	building, et	с. (Ѕреспу)			City or Town, State)					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical		hysician: To the best miner: On the basis o and manner sta	f examinatio								
	To the within 3 To the comple	Med	29b. Signature and title of certifier	1 = 0 0		^	29c. Licens	se number		29d. D	ate signed (Month	, Day, Year)	
?			1 H. C	ITEG +	101	(MV)	177	4164			p-14-0	pay, Year) 2009 rederick, M 2170	
(3/2		A. Zakaria 146	completed cause of d	eath (Item 2	3a) (Type,	Print)	ohnson	Drive	Ste	200 F	rederick, n	
j	Sta		31. Date filed (Month, Day, Year) JUN 2 4	32. 96 gistr	ar's Signatu	re	1					2170	
	Regist	rar	JUN 2 4	LUUS KANE	m ,	9. A	arke						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death Month Year Physician irairii lune 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) tospita rince octor's anham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Director 8/9/1941 McComick, 577-58-3618 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Marylan 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner ments to recitified at Yes 2 □ No Funeral Director Maryland Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 20706 9319 Wyatt Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married トレル・アンション アングラン アンファン Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black <u>ک</u> 3 ₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) alth and Mental Hygiene. Beauty Supply Manager ABC Beauty Supply 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Odel Segler Sara Quarles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra / Daughter Latanya Herron 2345 Vern Rd. Port Republic, Maryland 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 6/29/2009 Marvland Veterans Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lice of W 6005 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CArdio polnondry **Physician** /Medical Due to (or as a consequence of): Examiner CARDIAC FATAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Sepson burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Pneumonia Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 KNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Renal isease 1 ☐ Yes 2 € No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 2/DINO 1 □Yes 2 No EVEST within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State JUN 2 8 2009 Registrar

7009

ZZnd MDD 52865

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Filgaro, mD 12700 Good loes Promise Drive, BOWIE, md. 20720 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per MD G893 7-24.09 TT State of Maryland 7 Department of Health and Mental Hygiene Amend #2 per MD 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month June Day 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:30a Victoria Gruodis 18 2009 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 808 Merry Go Round Way Carroll Mt. Airy If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖼 F Yrs June 1, 1908 Russia Director 049-24-7788 101 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. and if item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, The Reginal Exeminar may be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 1 Yes 2 □ No **Funeral Director** Maryland Carrol1 Mt. Airv 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 808 Merry Go Round Way 21771 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 ☑ No þ Specify. 3 ☑ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mykolas Kazickas Katarina Sereickas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romualdas Gruodis / Son 4819 Westwind Drive, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 22,09 permit. Page Department c Important: If any Injury or Peter Catholic Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Libertytown, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. neral Service Licensee 21. Signature of F 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications to traused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SYEULI disease or condition resulting in death) mucchy /Medical Due to (or as a cons vuence of): Examiner When-enlion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed Division of Vital 1 ☐Yes 2 → No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending investigation 1 Natural To the Hospital co. ...
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier W Tune 19,2009 1929 dress of person who completed cause of death (Item 23a) (Type, Print) KB McInick MD 911 John Russell Avenue, Gaithersburg, Maryland 20879

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 4 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** Michael Guerrero II 12:25 Joseph June 18, M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Stockton 1419 Snow Hill Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 **⊠** M 2 □ F 49 226-76-4550 Director 11/27/1959 California Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County s 23a or 28a-f show 1 ☐ Yes 2 X No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 808 E. Church St. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 2000. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 7 is marked other than "natural", or items traumatic event, the Medical Evantions is 1 ∐Yes 2
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: white 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) electrical electrician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Carroll Joseph Michael Guerrero ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 73 County Road 342, Elba, AL 36323 Joseph Guerrero/father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service 22. Name and Address of Facility Holloway Funeral Home Professional Association Hallo 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of): Examiner LARYNGEAL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner TOBACCO ABUSE attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 X Yes 2 No 3 Probably 4 Unknown LIVER CIRRHOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ALCOHOL ABUSE autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Brother's Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28b Time of 28d. Describe how injury occurred

of Vital Records, P.O. Box 68760, Division To the Hospital o within 24 hours aff To the Funeral Di

death with the Maryland

or items,

signed by the a cate has t certificate or Attending Physician: this After thi funeral within 24 hours after death

To the Funeral Director: completely filled in by the f

Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number 06123

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Princers

D 218=33

State Registrar

Medical

			State of Maryland / Dep		Mental Hy	giene	2101.7			
			Registrar	ertificate of Death		Reg. No. CUU	0 7 1 3 1 1			
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Maria Carolina Hinestrosa		2. Date of Dea	Day Year	3. Time of Death			
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 2	21, 2009 4c. County of Dea	1:45 P M			
	Examin	er	5506 Hoover Street	Bethesda		Montgome				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	th 9. Bir	rthplace (State or Foreign ountry)			
	Director		318–76–8781 1□M 2X F 50 Yrs.	Months Days Hours Min.	Mar 7,		ombia, SA			
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1	ocation			10d. Inside City Limits			
	shov	ō	Total State 100. County 100. Gry, Town or I	Codion			1 □Yes 2 □XNo			
	the M	Director	MD Montgomery Bethesda 10e. Street and Number	10f. Zip Code		10g. Citizen of What C				
	with		5506 Hoover Street	20817		USA				
	Jeath	Funeral		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No					
9	after o		1 □ Never Married 2 🔀 Married 1 □ Yes 2 🛣 No	1 XYes 2 ☐ No Specify: Co			_			
93	hours after death with the Maryland tural", or items 23a or 28a-f show al Examination into the inclined at	d by	3 ☐ Widowed 4 ☐ Divorced	TALTES 2 NO Specify. W	LONDIAN	Specify: Hi				
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12	within ene. than	mp	Flementary/Secondary (0-12) College (1-4or 5+)	President		Non profit Public Hea				
2	filed within 72 Hygiene. other than "na ent, the Medic	o C	17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Surname)	<u> </u>			
Maryland 21215-0036	e d tal	To Be	Fabio Hinestrosa	Marina '	Villamiz	zar				
ary	should I and Men s marke umatic	_	19a. Informant's Name/Relationship (Type. Print)	ling Address (Street and Number or Ru	ral Route Numb	er, City or Town, State,	Zip Code)			
	and 2 lealth a m 27 is her trai		·	Hoover Street Be	thesda,					
altimore,	ges 1 and t of Healt If item 2 or other			position (Name of ematory or other place)	Date	20c. Location - City o				
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Bai	permit. Pages 1 Department of H Important: If iter any Injury or ott			Soing and Address of Facility tion						
	HD = 10 G		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	Severly L. Heckrot			le, MD 21029 Approximate			
		11. 1	shock, or heart failure. List only one cause on each line.	mer the mode of dying, such as cardiac	or respiratory a	irest,	Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death) Bilateral Breast Due to (or as a consequence of):	Cancer			years			
	Examiner			d Chest wall Sarco	ma		vears			
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	ecuter ind transi	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Right Extrapleura Due to (or as a consequence of):	al Pneumonectomy			weeks			
8760,	cate be executed physician and the burial-transit	Ě					ranalsa.			
287		dical	d. Right Chest Wall	resection reconst	ruction		weeks			
×	teath certific attending p	//Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23c. If yes, outcome of pregnancy						
Вох	death atter	Physician/M	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d	Day Year			
<u>Ч</u>	t the c by the achec	hysi	9 ☐ Unknown							
	w requires that the death certifi been signed by the attending should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute				
g	equire	ted	Metastatic Chest Wall Sarcoma		1 🗆 '	Yes 2A∑No 3∏i	Probably 4 ☐ Unknown			
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E	: The cate h	S			perfo 1 □ Yes	ormed? death? 2⊠No 1 □ Ye	s 2□No			
Ĭ	Physician: The land this certificate had rail director, page 2	Be	25. Was case referred to medical examiner?	26. Place of Dea						
	Phy:	٦.	1 ☐ Yes 2 ☒No	ent 3 DOA 4 D Nursing H		dence 6 Other (Sp	ecify)			
0	Attending Physir death. ector: After this oby the funeral dire	tion	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation			,,				
Division of	Atter	ifica	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or F	Rural Route Number,			
ā	tal or s afte al Dir ed in	Certification:			City or To					
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier (Check only (Ch	ath occurred at the time, date and place investigation, in my opinion, death occurrence.	e, and due to the arred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)			
	thin 2, the F	Medical	one) and manner stated? 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	oth Day Year)			
	N N N		The state of the s	D38159		June 22, 2				
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(302		Philip Charles Corcoran, M.D. 8600 (Betheso	da, MD 2081	4			
	Sta	te	31. Date filed (Month, Pay, Year) 4 2009 32. Fegistrar's Signature	1						
	Registr	ar	JUN 2 4 2009 June B.	Barke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:15 A M 2009 June 21 Charles Marcine Hartley, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Westminster Dove House 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Months Days Hours Maryland 1 X M 2 □ F 213-58-8438 June 3, 1950 59 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Frederick Braddock Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21714 USA 6117 Jefferson BLVD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ∐Yes 1 XNever Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Marcine Hartley, Sr. Nancy Rosella Fulcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine I. Adams/sister 7608 NW 38th Court Sunrise, FL 33351 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Final Journey Crematory 06/24/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Lice MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such lines. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) quence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

MD

7 is marked other than "natural"; or items 23a or 28a-f shov traumatic event, it a finalical Examiner must be notified at

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "reany injury or other traumatic event.

72 hours after death with the

Baltimore, Maryland 21215-0036

burial-trar detached

Examine and attending physician for use as the buria Physician/Medical the þ signed I \$ Completed peen cate has by page 2 s certificate director. Be this Certification: To After death.

25. Was case referred to medical

5 ☐ Pending investigation

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

the

within 24 hours after death

To the Funeral Director:
completely filled in by the 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 340 Owingsmills, mo russivads Dr. Registrar's Signature State 2009 4 Registrar Darke

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year JUNE 2009 20 Trudy D. Hercules 4a. Facility Name (If not institution, give street and number) Connty of Death 4b. City, Town or Location of Death Y CIVISTAMEDICAL LATA CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛣 F Months Days Hours 1073171948 235-78-0775 60 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 No Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3298 Ryon Ct 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 ☐No Specify: 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Lewis Hercules Sr. Richard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Melissa Robinson/Daughter</u> 303 Congressional Ct. Glen Bernie Md 21061 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/2009 Clinton, Maryland Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 191 Adams Funeral Home PA, Aquasco MD 20608 ations that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. art1. Enter the disease, or comp Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Thurse heres Sequentially list conditions, if any leading to min adults cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 Z No 1 ∐Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2. No 1 ☐ Yes 1 🔲 Inpatient 2 Z ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box O Ś Record Vital of

Physician: The ospital or Attending Phours after death.
neral Director: After ty filled in by the funera Division

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

2

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

Hygiene.

2 should be f

Pages

Department of Heall Important: If item 2 any injury or other

Physician

/Medical

Examiner

attending physician for use as the buria

signed by the a

s certificate has t irector, page 2 s

funeral director,

this

within 24 hours a

To the Funeral C

completely filled i Hospital

21215-0036

Maryland

Baltimore.

BR Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title at certifier

29a. Certifier (Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN SMITH MD 5 GARRET LAPLATAMD 20646 5 GARRETT

29c. License number

32. Registrar's Signature

JUN 2 4 2009

	1 - For State Registrar		Cert	rtment of tificate of			Reg.	200	9 9195	
n	1. Decedent's Name (First, Middle, Last)			14		Mor		Day Year	3. Time of Death	
al	JANARO HANA 4a. Facility Name (If not institution, give street and	number)		4b. City, Town,	or Location of	Death	<u>-4</u>	4c. County of Dea		
)r	The Johns Hopkins Hospital			Baltimor	e City	*	•			
	5. Social Security Number 6. Sex 1 🛣 M 2 🗆	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Days		Min. (Mo	e of Birth nth, Day, Yea 1 2, 19	ar) Co	rthplace (State or Foreigi ountry) ndia	
	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City Limits	
ctor	Maryland Frederick			Frederi	.ck				1 □ Yes 2 🙀 No	
Funeral Director	10e. Street and Number 4900-A Meridian Way, Aparts	ment 8		10f. Zip-Code	21703		10g.	Citizen of What Co India	ountry?	
by Funera	Arme 1 Never Married 2 Married 1 1 If Yes	Decedent Ever In U.S. d Forces? 'es 2 X No , Give or Dates:	l If	Vas Decedent of Yes, specify Cu	ban, Mexican,	in? (Specify Yes Puerto Rican, e	or No-	14. Race - Am Black, Whi Specify: A		
	15. Decedent's Education (Specify only highest grade comple	ted)		dent's Usual Occupation label				o. Kind of Busines	s/Industry	
Completed		ge (1-4 or 5+)	life. D	intendent				Indian Pos	tal Services	
To Be C	17. Father's Name (First, Middle, Last) Narnapaih Annangala Holla				18. Mother	r's Name (First, Sitamma	Middle, Mai	iden Surname)		
	19a. Informant's Name/Relationship (Type. Print) Ram Sarma / Son-in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 4900-A Meridian Way, Apartment 8, Frederick, Marylan									
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To								r Town, State	
	1 Burial 2 Temoval from State 4 Donation 5 Other (Specify) Smithsburg Crematory July 8, 2009 Smithsburg, Maryland									
	21. Signature of Funeral Service Cloensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home									
	M01433 106 Fast Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	shock, or heart failure. List only one cause on each line.									
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	Immediate Cause (Final disease or condition resulting in death)	Sesis e to (or as a consequence adioge		hock					Onset and Death	
aminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sepsis e to (or as a conseque e to (or as a conseque 1400adia	nic S		07				Onset and Death	
cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	adioge e to (or as a conseque	nic S ence of):		07				Onset and Death 24 H 47 Days	
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by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	e to (or as a consequence to (ence of): 1 T rency death 3 ath 5	Ectopic pregna	ncy	28		Month	Onset and Death 2'4 H 47 Days 47 Days elivery Day Year	
by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	e to (or as a consequence to (ence of): 1 T rency death 3 ath 5	Ectopic pregna	ncy		1 Yes a. Was an	Month co use contribute 2 \(\sum \text{No} \) 3 \(\sum \text{F} \) 24b. Were a	Onset and Death 24 H 47 Days 47 Days elivery Day Year to the cause of death? Probably 4 Unknow autopsy findings availab	
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KB State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOY(E) E Brown Johns Hopkins Hospita)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

			State of Maryland / Dep		lental Hyg	iene	
			Registrar	rtificate of Death		eg. No. 2000	3. Time of Death
1	Physicia	an	1. Decedent's Name <i>(First, Middle, L</i> ast) Joseph Donald Hayden, Jr.		2. Date of Death Month	Day Year	214
-	/Medic	al		Ah City Town or Leasting of Dooth	June	30, 2009 4c. County of Death	8:48 am
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		St. Mary	
忒	F		St. Mary's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Leonardtown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	-	ace (State or Foreign
	Funeral Director		214-34-6979 1□ M 2□ F 71 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 01/11/19	Year) Counti	ry)
			Usual Residence of Decedent			Trairy	Tana
	rylan how	L	10a. State 10b. County 10c. City, Town or L			10	d. Inside City Limits
	e Ma	cto	Maryland St. Mary's Valley I	₁ee			1 □Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Countr	ry?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show files Evanified and a count to rediffed at	ral	45603 Drayden Road	20692		USA	
	tems	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - America Black, White, et 	
36	s afte	by F	1 ☐ Never Married 2 ☐ ※ Married 1 ☐ Yes 2 ☐ * No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
21215-0036	hour tural	ed k		edent's Usual Occupation	1 -	16b. Kind of Business/Indu	
15	in 72 n "na fortic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)		Top. Tana of Edomodo inde	, ou y
212	l within giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	armer		Farming	
	be filed within 72 hd htal Hygiene. do other than "natu event, in Mouland	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N	faiden Surname)	
Maryland	should be filed wand Mental Hygies smarked other thumatic event, In	To E	Joseph Donald Hayden, Sr.	Cather	rine Ros	salie Knott	
ar	2 short and he is ma			ing Address (Street and Number or Ru			Code)
	t 23 mg		Nancy M. Hayden (Spouse) 4560	3 Drayden Road, Va	alley Lee	e, MD 20692	
Baltimore,	es 1 a of Hea fitem rrothe		20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition certain control of the state of	osition (Name of ematory or other place)	Date 2	20c. Location - City or Tov	vn, State
Ĕ	permit. Pages: Department of I Important: If ite any injury or of		4 □ Donation 5 □ Other (Specify) St. Geor	ge Catholic 07/0	3/2009 V	alley Lee, N	MD
at	permit. Depart Import any inj once.			2 2. Name and Address of Facility \mathtt{Brf}	nsfield	Funeral Home	e, P.A.
ш	20 E % 9	N)	Kyle Simons M01206	22955 Hollywood RI	., Leona	ardtown, MD	20650
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
E.	Physician		Immediate Cause (Final disease or condition	Ribuillation	*	T.	Onset and Death
2	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	LABITITIES	<u>.</u>		mia.			14
	ted sit	Examiner	d any leading to immediate cause. Enter Underlying Cause (Disease or injury				
	xecur and	xan	that initiated events resulting in death) Last				
68760,	icate be executed physician and the burial-transit	<u>a</u>				ļ	
687	ificate g phy: s the	edical	0.				
Box	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
	death certif e attending ed for use as	icia	in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		Month [Day Year
P.O.	t the by th ache	Physician/Me	9 Unknown				
	law requires that the death certifi as been signed by the attending 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
Records,	en sig	ed	Lung Causin	•	1 ☐ Ye	es 2 No 3 Proba	ably 4 Unknown
ပ္ပ	law re as be 2 sho	plet	0		24a. Was ar autops		sy findings available
<u> </u>	The ate h	Completed			perforn	ned? death? 2 ☑No 1 ☐ Yes	
/ita	ilcian: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one		
of Vital	Physician: r this certific ral director, I		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing H	ome 5 Reside	ence 6 Other (Specify)
Ē	nding Physician: th. : After this certific: : funeral director, i	on:	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury	Work?	28d. Describe ho	w injury occurred	
<u>s</u> .	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be 280 Blood of Injury. At home form of	M 1 □Yes 2 □No			
Division	or Al	Certification: To	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town	reet and Number or Rural n, State)	Route Number,
_	purs and lead filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the c	auca(e) and mannar ac et	atad
	24 hose Fun	Medical	(Check only one) Check only one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Check one Che	nvestigation, in my opinion, death occu	rred at the time, da	ate and place, and due to	the cause(s)
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of centiles	29c. License number	29	9d. Date signed (Month, D	Day, Year)
			Laur M.D	D 60889	3	07/01/	09.
1			30. Name and address of person who completed cause of death (Item 23a) (Type			- /	
alle	/			okout Road, Leonai	dtown, M	1D 20650	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hand I			
	Registr	1	JUL 0 1 2009 deman A. A				

DHMH 17 Rev 1/2001

				1 - State of Maryland / Department of Health and Certificate of Death		iene 2009	21952
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death
		/Media	cal	Mabel K. Hopkins	July	1 2009	0039 M
		Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea Harford Memorial Hospital Havre de Gra		4c. County of Death	1
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	S. 8. Date of Birth		place (State or Foreign
	н	Director		215-16-9520 1 Max 86 Yrs. Months Days Hours Min	April 3	, 1923 Mary	rland
		D s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		n the Marylan r 28a-f ehow tradilited at	ō	Maryland Harford Aberdeen			Yes 2□No
		28a-	Director	10e. Street and Number 10f. Zip Code	11	0g. Citizen of What Cou	intry?
		th with		1 Baldwin Circle 21001		USA	
		deet ma 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
5	36	or ite	y Fu	1 Never Married 2 Married 1 Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: whi	
0	5-0036	hours furel,	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/li	
1	215	in 72 n ne	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	orking	TOO. KING OF BUSINESSAN	idustry
1	212	d with giene.	lmo:	Selementary/Secondary (0-12) College (1-4or 5+) 9 home maker		in home	
7		be filed within 72 hours after deeth with the Maryland Ital Hyglene. d other then "neturel", or Itema 23a or 28a-f ehow event, tra Medical Examinar must be confilled at	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Na	ime (First, Middle, M	Maiden Surname)	
	yla		To	Harry Burkentine Dell	a Lungre	n	
	Maryland	d 2 should th and Mer 7 te marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			p Code)
6		1 and 1 and		William L. Hopkins, Jr. (son) 2 Baldwin Circle, Ab 20a. Method of Disposition (Name of		LD ZIUUI 20c. Location - City or I	own State
3	Ď	S		ty☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		7-9	
0	Baltimore,			4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility		Aberdeen, N	
0	Ba	permit. Departr Imports any inju		Kusten One Waleshie Aberdeen, Marylan	arring-Ca d 21001-3	rgo Funeral	Home, P.A.
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.		est,	Approximate Interval Between
		Physician	П	Immediate Cause (Final disease or condition			Onset and Death
		/Medical		resulting in death) Due to (or as a consequence of):			
	1	Examiner	L	Sequentially list conditions, b. Counties Thursday			
		ed ssit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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	.89	tificate g phys as the	edic				
7	ŏ	eath certifica attending ph I for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	· ·
9	Э. В	e deal he att	sicie	in the past 12 months? 1 □ Yes 2 ☑ No 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
3	P.0	that the ded by the detached	Phy	9 Unknown	oza Didaah		the serves of death?
کے	rds,	sign d be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 🗆 Ye	bacco use contribute to es 2 No 3 Pro	
. [-	ecor	law reques been 2 should	Completed	· /	24a. Was a autops	n 24b. Were au	opsy findings available ompletion of cause of
7	Œ		Com		perform	med? death? 2 No 1 ☐ Yes	212 No
2	/ita	iclan: Th certificete rector, pag	Be	examiner/	eath Check only on	10)	
7	of	Phys this aldii	5	THE RESERVE THE PARTY OF THE PA	· · · · · · · · · · · · · · · · · · ·	ence 6 Other (Spec	ify)
5	, LO	ding h. After funer	tlon	Natural 5 Pending (Month, Day Year) Injury Work?	200. Describe no	ow injury occurred	
I	Divisi	or Attending ifter death. Director: After in by the fune	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (St	treet and Number or Ru	ral Route Number,
	Θ	s after	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town	n, State)	
		To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation and the basis of examination and/or investigation and the basis of examination and/or investigation and the basis of examination and the basis of exa	ce, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month	, Day, Year)
)	. •		D4092:	2	July Z Z	009
				30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)	a 1/	Up F.	·
				JAH WACKSMAN 401 JOCUM WILLOW AM	House	de GEACE	10
		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrate Signature	/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Margaret Keener 02:28 AM 22, 2009 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 💢 F Maryland 71 Nov 11, 215-34-4105 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼ No Myersville Maryland 10f. Zip Code 10g. Citizen of What Country? Street and Number 4207 B. Coxey Brown Road 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 200No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) school bus driver education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Richard Harding Margarette Cromwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 B Coxey Brown Road, Myersville, Maryland 19a. Informant's Name/Relationship (Type. Print) 21773 Richard Keeney - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Church of the Brethren Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 25–2009 Myersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Luo Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No

Physician /Medical Examiner Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, If a M once.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Director

Funeral

ģ

Completed

Be

P

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tra use as for signed pe director, page 2 should certificate filled in by the funeral

Physician/Medical

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Completed

Be

ical Certification: To

Hospital or Attending Physician; The law requires that the death certificate be executed

after death

24 hours a Funeral I

the within ? completely

12

Division of Vital Records, P.O. Box 68760,

9 Unknown Hypertension

27. Manner of Death

1 X Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

Atrial Fibrillation

1💢 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury accurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

29c. License number 18141

29d. Date signed (Month, Day, Year) 22,2009

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland

22 South Greene Street, Department of Neurology, Anne Finkbiner, MD Baltimore, Mayland 21201

State Registrar

31. Date filed (Month, Day, Year) JUN 24 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kelley-Hall Mary Margaret 1.30AM 06 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Lax Wicomico 94 isbur HOSDICE If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year **Funeral** Days Hours Months 1 □ M 2 🗙 F 215-38-2035 69 03/14/1940 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the The dick Evaninar must be motified at 1 ☐ Yes 2 🙀 No Director Berlin Maryland Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 100 Martinique Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Be Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) vice president banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Archie P. Tyler Mary E. Landon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 MartiniqueCircle, Berlin, MD 21811 19a. Informant's Name/Relationship (Type. Print) Willis Hall/spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If It any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 6/25/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on its in line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate ∣∐Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) V 29505 06-24-2009 20. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD Z1801

1. Date filed (Month, Day, Year)

32. Registrar's Signature,

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 0900 2009 Azalee Page Lattimore June 22, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville 1723 Albert Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 65 Director NC 08/07/1943 579-56**-**6834 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 X Yes 2 □ No Mitchellville Director Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 1723 Albert Drive death v USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) as 1 and 2 should be fill of Heelth and Mental H Be Christana Balloon Booker T. Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1723 Albert Drive, Mitchellville, MD Albert Lattimore/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ital
eny injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Limcoln Memorial 06/26/09 Suitland, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licenses 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Netasta Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 DNo 9 ☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 1 ☐ Yes To the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Melisande Smith, MD,

MP

1221 Mercantile Lane, Upper Marlboro, MD

1)0063558

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lehman Arthur W. June 19 2009 2:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6004 Auth Road Camp Springs Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1√ M 2□ F 187 18 3203 91 Director Sept 24, 1917 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Exemit at must be realfied at 1 □Yes 2□No Director Maryland Prince George's Camp Springs filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6004 Auth Road 20746 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 □ Yes 2 □ YNY Specify. þ Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Musician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill Health and Mental H tem 27 is marked ott Be Harry Lehman Ada Wismer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Frieda D. Lehman - Wife 6004 Auth Road, Camp Springs, MD 20746 20a. Method of Disposition
1 Burial 244 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Lee Crematory June 23, 2009 Clinton, MD 4 ☐ Conation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee MU139 Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 2 years 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pulmonary Fibrosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 14 ■ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗋 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 22, 2009 D 28281 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name ai

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31. Date filed (Month, Day,

Year)

JUN 2 4 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

parke

Nelson Benjers, 9131 Piscataway Road, Clinton

Registrar's Signature

			State of Maryland / Department of Health a	and Mental H	ygiene	
			1 - State Registrar Amend#26.PerMEPGC6-26-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.	21951
	Physici		LESLEY MILES	Month	Day Year	3. Time of Death
-	/Medio		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location o		4c. County of Dea	
-	LAGIIII		219 Kende Street Upper M.	Arlbore	Prince	6 cores
	Funerai		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If Under 2 19-04-2395 1 M 2 \frac{1}{2} 38 Yrs. Months Days Hours	Min. (Month, I	Birth 9. Bi Day, Year) C	rthplace (State or Foreign country)
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	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	with th	Ö	10e. Street and Number 7653 ALLENDALE CIRCLE 10f. Zip Code 20785		10g. Citizen of What C	country?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show diest Examinat must be routiled at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status	gin? (Specify Yes or N		erican Indian,
9	after o	Fur	Armed Forces? 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, 1	, Puerto Rican, etc.)	Black, Whi	te, etc.
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	ld be filed lental Hygi ked other ic event, II	Be (274 (77)	r's Name <i>(First, Midd.</i> HANTA A. B	lle, Maiden Surname)	
Maryland	should be and Ments s marked umatic ev	은				
Ma	00		19a. Informant's Name/Relationship (Type. Print) LESTER M. MILES/FATHER 19b. Mailing Address (Street and Numbe			
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Ë	Pages ment of l ant: If Its wry or o		WD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 7	7/2/2009	CHELTENHAM	MARYLAND
Baltimore,	permit. Pages Department of Im ortant: If It any intery or c		21. Signature of Func Service Usersee 22. Name and Address of Facility	0, 0,	ENKINS FUNE	
	10200		7 4 7 4 LANDOVER IS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as			7
Į	Physician		shock, or heart failure. List only one cause on each line.	1	4.	Approximate Interval Between Onset and Death
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	Examiner	_	Sequentially list conditions, b.			
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68760,	icate be executed physician and the burial-transit	dical	d			
		w	IF FEMALE:			
Вох	leath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Vas 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of d Month	elivery Day Year
P.O.	t the d by the ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
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ā	ificate		25. Was case referred to marical 26 Place	1 □ Yes		s 2 📉 No
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	determined determined determined determined determined determined determined determined determined determined		(Street and Number or F own, State)	Rural Houte Number,
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	To the Howithin 24 To the Fu	ledical	one) and manner stated.	th occurred at the time		
	5 4 kind	Σ	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	th, Day, Year)
	.,	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	71	June ho	1009
/	Va		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADOR SIJNSTER 3 CM) HOSSITAL DRIVE CO 31. Date filed (Month, Day, Mar) 32. Registrar's Signature	heverle	MANGE	d
	Sta		31. Date filed (Month, Day, War) 32. Registrar's Signature	11		
	Registra	ar	AND THE PARTY OF T			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUNE 22, THEODORE MATHIS 2009 9:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BOWIE PRINCE GEORGE'S BOWIE HEALTH CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 🕅 M 2 🗆 F 1/30/1942 579-54-1683 67 Washington, Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 11√ Yes 2 No Maryland | Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1311 Early Oaks Lane 20743 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify. Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Dorothy Mathis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Govan Mathis /Wife 1311 Early Oaks Ln. Capitol Heights, MD. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 MULCOS 23a. Part 1. Enjer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STOMACH CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2√√ No 24a. Was an autopsy performed? 1 □ Yes 2√□ No

Physician /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once.

Physician

Examiner

Funeral

Director

28a-f show

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or items 23a

2 should be filed within 72 hours after on and Mental Hygiene.

altimore, Maryland 21215-0036

Box 68760

P.O.

event, the Medical Examiner must be notified at

Directo

Funeral

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Completed

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death with the Maryland

/Medical

Examine burial-transit attending physician for use as the buria Physician/Medical signed by 2 page 2 should Completed certificate director, funeral (

The law requires that the death certificate be executed

State Registrar

Division of Vital Records, e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🙀 Natural 2 🔲 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No completely filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 24, 2009 D45217 30. Name and address erson who com d cause of death (Item 23a) (Type, Print) Greenbelt Road Suite M18 Greenbelt, Maryland 20740 6201 MD Adebowale

31. Date filed (Month, Day, Year) JUN 2 8 2009

			State of Maryland / Department of Health and Mental Hygiene
A	mende	£	= State Registrar 6 / 24 / 09, MD # 26, TCHD, Sertificate of Death Reg. No. 2 959
4	Physicia /Medic	-	1. Decedent's Name (First, Middle, Last) Alda W. Myers 2. Date of Death Month Day Year 06 16 2009 7:26a M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
<u> </u>		- 5	700 Port St. Easton Talbot
į.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Country) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 9. Day
	Director		146-18-6262 98 Yrs. 12/01/1910 PA
	/land ow at		10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits
	a-f sh iffed	tor	MD Talbot Easton 1√X Yes 2□No
	or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	23a ust b		700 Port St. 21601 USA
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 □ No Specify: Specify: Black
21215-0036	filed within 72 hours after death with the Manyland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	hin 72 e. an "na Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
2	d with	mo:	12 5+ Librarian Board of Education
2	tal Hy d oth	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
<u>ya</u>	Meni Meni arked atlc e	2	Isaiah Wilson Ada Golden
Maryland	12 sh n and r Is m		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corinda Waters/ Friend 805 High St. Cambridge, MD 21613
e,	1 and Health em 2		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any fiurry or other traumatic event, the Medical Examiner must be notified at once.		1½ Burial 2 ☐ Cremation 3 ☐ Removal from State
Ħ	artme artme ortan Injur	1	21. Stand of Funeral Times Ucensee MD Veteran MD Veteran 106/22/09 Hurlock, MD 22. Name and Address of Facility Bennie Smith Funeral Home
Ba	permi Depar Impor any Ir	•	426 E. Dover St. Easton, MD 21601
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
7	Physician	í	Immediate Cause (Final disease or condition
A.	/Medical		resulting in death) Due to (or as a consequence of):
	Examiner		Sequentially list conditions. b
	sit ed	Examiner	Sequentially list conditions, if any, leading to immission cause. Either Underlying Cause (Disease or injury that initiated events.) Set the Underlying Cause (Disease or injury that initiated events.)
	xecut and II-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last C
8760,	icate be executed physician and s the burial-transit	alE	
687	fficate g phys	edical	
	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery
m	death e atte	Physician/M	in the past 12 months? 1
Ö	at the by th tache	hys	9 Unknown 9 Unknown
Records, P.O. Box	w requires that the death certificen signed by the attending I should be detached for use as	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
ord	een s	ted	1 Yes 2 No 3 Probably 4 Onknown
ec	e law	Completed	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
E	: The		performed? death? 1
Viital	siclan certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital: 4 Description of Death Check onl one Control of Death Check onl one Check onl one Check on
	Phys rthis ral dii	- T	1 Yes 2 No Pospital 1 Inpatient 2 ER/Outpatient 3 DOA VITE 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 4 Nort? 28b. Time of Vort? 28b. Describe how injury occurred Work?
on	dlng th. : Afte fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No
Division or	Atter r deal ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office 28t. Location (Street and Number or Rural Route Number,
Ö	s afte	Certification:	4 Homicide building, etc. (Specify) City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	thin 2 the 1 mplet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	₹ ¥ 5 8		NO 0 63260 6/2210
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	10		Sohail Aman, MD 302 Collins Ave Hurlock, Md. 21643
	Sta	ite	31. Date filed (Month, Day, Year) 32. Begistrar's Signature
П	Registi	ar	JUN 2 4 2009 / Same & Market

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Charles Paul Montgomery Jul 4, 2009 12:30am Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12518 Sunshine Drive Cumberland Allegany 9. Birthplace (State or Foreign Country)

MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 31, 19 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 218-34-2504 Director 73 1935 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Fyments. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 □Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12518 Sunshine Drive 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ Xio If Yes, Give Year or Dates: Specify. Completed by Specify: 3 Widowed 4 Divorced Korea white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Kelly Springfield Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Paul Montgomery, Sr. Katherine Alma (Burkhart) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Montgomery wife 12518 Sunshine Drive Cumberland MD 21502 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 7/6/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Errier the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line.

Immediate Cause (Final disease or or addition resulting in that)

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** YEMPI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Mo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title JULY 6, 2009 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) LAVACE MO 21702 1668 WATTOWAL HIGHWAY MOEN M.D. 31. Date filed (Month Registrar's Signature Day, Year) State Barto 0 9 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 2009 11:07 A Marilyn Elizabeth Morton June 29, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Big Pool Washington 12715 Pecktonville Road 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1934 **Alabama** Director 253-66-1852 14, Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Expraigned to profit a space. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Director 1 ☐ Yes 2 No Big Pool MD Washington 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12715 Pecktonville Road Funeral 21711 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Income Tax Preparer Accounting 3 1/2 yrs.18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Elgin Avery, Sr. Mayme Exa Cooper ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Bright/Daughter 12715 Pecktonville Road, Big Pool, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Point City Cem. 7/2/2009 West Point, GA 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dieve Physician /Medical Due to (or as a consequence of) Examiner pro Vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the irrector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ me trition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed Decubitus alces 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 XXINo 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely file 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 29c. License number D35493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL CT. HACERSTONN, MUS 21740 TASHA 112) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Claude Outten 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not ipstitution, give street and number) Examiner icomico Dice Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 12/08/1920 Months Days Hours 1 🕱 M 2 🗆 F Maryland 176-18-6616 88 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Mycleal Examinat must be redified at 1X Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 72 hours after death with 1514 Riverside Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, GivCoast Guard Specify: ð 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trainmatin. College (1-4or 5+) Elementary/Secondary (0-12) agriculture farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dolsie Blades Lora P. Outten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7516 Walston Switch Rd., Parsonsburg, MD 21849 Teresa Boggs/daughter Limore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from State Pocomoke City, MD 6/25/09 4 □ Donation 5 □ Other (Specify) First Baptist Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Ass Holloway Funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Funeral Home Professional Association Kett R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-transil Due to (or as a consequence of): Box 68760. Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month signed by the atte Dav Pregnant at time of death 5 Other (specify) ∃Yes 2 □ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2/1No Other: 4 ☐ Nursing Home 5 ☐ Residence Hospital: 6 Sther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 142 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO058410

State Registrar Name and a

Huysen

31. Date filed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print)

BOX

32. Registrar's Signature

20

JUN 25 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month S. PawLing **Physician** 2137 24 2009 ARthur 66 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) SALISBURY WICOMICO LAKESIDE ASSISTED LIVING 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 07/18/1914 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Months 1[XM 2□ F Yrs. 057-14-5425 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth end Martal Hygiene. Important: if Item 27 is marked other than "naturel", or flems 23a ~ "" ADD. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Directo Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 902 Winding Way Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bendix Corporation vice president 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Landwehr Arthur Shepard Pawling Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 Winding Way, Salisbury, MD 21804 Dorothy Pawling/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/26/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP domosort 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASOVO Examiner Physician/Medical Examiner Demen 49 or Attending Physician: The law requires that the death certificate be executed Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury **Pug** ate has been signed by the attending physicien page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical 15515/ed Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No iours efter deeth. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) .4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6-25-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 5 DIVISION SWELL BUISBURY ND 2/804 NATESAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28 f per ME 2894 8/27/09 TT Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jue 22 1830 M 2009 Jean Wilson Randolph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Trince 6 core Leverl Hospital If Under 1 Year | If Under 24 Mrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec. 30, 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 F 90 1918 Maryland Dec. **Director** 579-18-9638 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f shovevent, the findical Evanitation for additional 1 X Yes 2 □ No Director Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 135-47th Street N.E. United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, its. Modical Exercits and any Injury or other traumatic event, its. Modical Exercits and once. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: African 3 X Widowed 4 Divorced Completed 16b. Kind of Busines and s 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman J. Wilson Bertina Holland ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah R. Harrison/ Daughter 9612 Teakwood Drive Largo, Md. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Landover, Maryland 30, 2009 Harmony Memorial 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the orde of dying, such as cardiac or respiratory arrespinct, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque of of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Josaes or night) that initiated events resulting in death) Last Due to for as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions th but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred Fell 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Aatural 5 Pending investigation struck head at June 20,2005 28e. Place of Inury - At I on building, e.c. (Specify) 0600 M 1 □Yes 2.☑No 2 Accident 3 ☐ Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 35 47 H 5 H Washington, D At lome, farm, street, factory, office 4 Homicide nome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed Month, Day, Year, 29b. Signature and title of certified 30. Name and add who completed cause of death (Item 23a) (Type, Print) lana filed (Month, Day, Year) State JUN 2 6 2009 Registrar

			For State Registrar	State of Maryland	d / Department of F Certificate of I			iene _{9g. No.} 2 () () 9	21965
	Dharisi		1. Decedent's Name (First, Middle, Last				2. Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic			anch			06	18 2009	
	Examin Funeral Director		4a. Facility Name (If not institution, give UNICCS: +4 Mar 5. Social Security Number 6. Se 484-06-6002	y land Medica	ast birthday) If Under 1 Year		8. Date of Birth (Month, Day,	Year) Co	n hplace (State or Foreign untry) Moines, Iowa
	ъ		Usual Residence of Decedent	100 Cih	/, Town or Location			7	10d. Inside City Limits
	arylar show	J.	10a. State 10b. County Prince	General Loc. City	podrews Air	Fores	Base	-	1√Yes 2 No
	the M	Director	10e. Street and Number	ocorges /	10f. Zip Code	2/0/02	1	0g. Citizen of What Co	ountry?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Midcal Event and recording at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hif Yes, specify Cub. 1 □ Yes 2 ☑ No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes <i>o</i> r No- Rican, etc.)	14. Race - Ame Black, White Specify: W	e, etc.
5-0036	2 hou		15. Decedent's Edu	ication	16a. Decedent's Usual Occup (Give kind of work done	pation		16b. Kind of Business/	Industry
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anc	d be fi) Be	Allan H. Rauc	h		Carmel:		Nigro	
Maryland	should and Me mark umati	욘	19a. Informant's Name/Relationship (T)	ype. Print)	19b. Mailing Address (Street	and Number or Rura	I Route Number	r, City or Town, State,	Zip Code)
Ž	and 2 ealth a n 27 is		Lindsay Rauch -		2099 Madison				
altimore,	t of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4	20b. P	lace of Disposition (Name of emetery, crematory or other pla	^{ce)} June 26,	2000	20c. Location - City or	
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Ba	Depa Depa Impo any ir		21. Signature of Funeral Service Licens	see mols	33 22. Name and Addres 6633 01d A	Alexandria	Ferry	al Home, In Rd., Clinto	on, MD 20735
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The same	Physician		Immediate Cause (Final disease or condition resulting in death)	a Branchiolit	is obiterals o	rojani 212	g PNE	uninja	3 weeks
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O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 Ectopic pregnant	су		23d. Date of de Month	elivery Day Year
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o	Phys r this ral dir	- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 100A	4 Li Nursing no		lence 6 Other (Sp low injury occurred	ecify)
o	Attending Physician: The sr death. ector: After this certificate h by the funeral director, page	ition	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	28b. Time of 28c. Inju Injury M 1	irk? ∐Yes 2.⊠No			
Division of Vital Records,	tal or Attenus after death	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, office fy)		28f. Location (S City or Tow	Street and Number or F n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phyone) Check only 2 Medical Example 1	yslcian: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurred at the tation and/or investigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
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			mary M	showshi a	RNP RU	80136		06/18	12009
	RAF		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	11		Logat A	/2009 affinore AD
	Sta	te	Mazia 31. Date filed (Month, Day, Year)	32. Registrar's Signa	dd J64	The Gree	ene J	mee! U	2/201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 **Physician** June 19, 10:17A ^M Seymour W. Ruff. Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Citizens Care Nursing & Rehab Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Hours 80 July 11,1928 Maryland Director 217-22-4093 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 XYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21701 USA 6344 Springwater Terrace #1124 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give WW II Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No WW II Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Seymour Ruff, Sr Mary West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thea Uhlig-Ruff/Wife 6344 Springwater Terrace #1124 Frederick,MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 6/20/2009 Stauffer Crematory Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA Signature of Funeral Service sicensee brule 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** astinson /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Universiting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination ad/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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the

State Registrar

Robert L. Kaufmann 31. Date filed (Month, Day, Year) JUN 24

30. Name and address of person who completed cay

29b. Signature and title of certifier

Ninth Street, 32. Segistrar's Signatu

se of death (Item 23a) (Type, Print)

and manner stated.

Frederick,MD 21701

29c. License number

D-13971

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** STAVELY OLIVE М JUNE 19. 2009 2200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY

| If Under 24 Hrs. | If Under 24 Hrs. | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | Alin | WICOMICO SALISBURY REHAB AND NURSING CENTER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours 1 □ M 2 🕱 F 206-12-3338 85 DEC 29, 1923 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 40 MT. PLEASANT AVE. 21601 Funeral USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: WHITE \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK STATIONARY Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SON DAVID M. STAVELY, JR. 5898 CUMBERLAND DR. SALISBURY, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 ★★remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION JUNE 22, 2009 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST. EASTON, MD 21601 HOME, P.A. C.F.SP m. Ostrowsk. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0/6/ year. **Physician** 4 /Medical Due to (or as a con a quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami aftending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of cortife 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a 21800 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death Month

Dhysisian	
Physician	
/Medical	
Examiner	

Directo

Funeral

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Completed

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Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine burial-tran attending physician for use as the buria Physician/Medical To the Hospital or Attending Prystoan, many within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. ۾ Be Completed Medical Certification: To

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed 6 KB State Registrar 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Charlotte Lily Scheidegger 22 7:40<u>June</u> 20094a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick College View Center Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) Months 1 □ M 2 🛛 F 76 Dec. 1, Virginia 214-28-4608 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TYPes 2 □ No Maryland | Washington Williamsport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 227 Maplehurst Avenue 21795 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married White 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Judson Heflin Virginia Lane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Maplehurst Ave., Williamsport, MD 21795 Robert Scheidegger/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens June 26 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licens <u>9501 Catoctin Mtn. Hwy. Fredérick. MD 21701</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or couplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme te Cause (Final dise de or condition resi ting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 25. Was 1 27. Man 12 2 🗆 з□

								24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referred to medical examiner?							Place of Dea	th (Check only one)		
1 Yes 2	No	Hospital	: 1 ☐ Inpatient 2 [☐ ER/Outpatient	3 🗆 🛭	Other:	Nursing H	ome 5 Residence 6	☐ Other (Specify)	
27. Manner of Deat 1 ☐ Natural 2 ☐ Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury	occurred	
3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	28e.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						8f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only	1 Certifying Ph 2 Medical Exan	ysician: niner: Or	To the best of my kr	nowledge, death	occurre	d at the time, on, in my opinion	date and place	e, and due to the cause(s)	and manner as stated. place, and due to the cause(s)	

					115)		
30.	Name	and add	lress of person	who completed	cause o	of death (Item 23a)	(Type,	Prin

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

31. Date filed (Month, Day, Year)

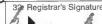
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 20, 2009 7:02 PM^M Doris Margaret Schildt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 7719 Sundays Lane 8. Date of Birth (Month, Day, Year) Nov. 21, 1934 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mary land 1 □ M 2 🖾 F 74 219-34-5441 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland ntal Hygiene. 10h County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hydical Examina" must be motified at 1 □Yes 2 No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 21702 United States 7719 Sundays Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oneida Belle Welty Charles Floyd Eyler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 7719 Sundays Lane, Frederick, MD 21701 Department of Health a Important: If item 27 is any injury or other tra Carroll L. Schildt / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Puneral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between 23a. Part 1. Enter the diseas shock, or heart failure Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 ponths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.0. cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa

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Registrar



address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Fredorio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** SMITH 2009 JUNE /Medical Facility Name (If not institution, LEASANT VIEW 4a. Facilify Name (If not in, PLEASANT 410) 0-0 4b. City, Town, or Location of Death 4c. County of Death Examiner MOUNT ARROL f Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 80 215-28-4218 Nov.11,1928 Maryland Usual Residence of Decedent 10c City Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Mt. Airy Maryland | Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a 7922 Dogwood Drive 21771 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 Is marked attack Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Arthur Osborn Rose Koenig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Smith/ Husband Dogwood Drive, Mt. Airy, Maryland 21771 Dosition (Name of Date 20c. Location - City or Town, S 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery June 24,09 Mt. Airy, Maryland 22. Name and Address of Facility. Stauffer Funeral Homes P. A. uneral Serv 21. Signature 1621 Opossumtown Pike. Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Examiner death certificate be executed the burial-transit and Due to (de as a consequence of) P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s autopsy performed Ž□ No Division or Vital or Attending Physician: Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manpel of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pragner stated.

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State Registrar

31. Date filed (Month, Day, Year) JUN 2 4 2009

29b. Signature and title of certifie

Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month O G 7:00 **Physician** Marcinia Stephenson 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Salisbury castal LAKE WICOMICO pice at the f Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Sex Social Security Number **Funeral** Months Days Min. Hours 1 ☐ M 2 🕱 F 217-07-9539 91 07/10/1917 Virginia Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Medical Examination that the modified at 1 ☐ Yes 2 🕱 No Director Wicomico Hebron Maryland 10f. Zip Code 21830 10g. Citizen of What Country? 10e. Street and Number USA 27257 Ocean Gateway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11 Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ▼No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) shirt manufacturing worker 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Sallie Fletcher Wilmer E. Downing ည 19b. Majlion Address (Street and Number or Rural Route Number, City or Town State, Zip Code)
27257 Ocean Gateway, Hebron, MD 21830 19a. Informant's Name/Relationship (Type. Print) Scott Turner/grandson 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 7/6/09 Hebron, MD 4 Donation 5 Dother (Specify) Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 2<u>1</u>804 Signature of Funeral Service Licensee Parid H. (homoson) CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any learning to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 🗌 Yes Completed peen a 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy this certificate has 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) HCS 2:No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Hospital or Attending Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 24 hours after death Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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DHMH 17 Rev 1/2001

State Registrar 6 Huntin

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PU

, BOK 32. Registrar's Signature DOOS 7410

Skry Bury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day $P^{\!\mathsf{M}}$ Physician 3:10 Edward R. Smith 2009 July 1, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick 593 Cawley Drive, Unit 1A Frederick If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) January 3, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Min 1 X M 2 □ F Ohio 277-12-6867 87 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at Frederick Frederick 1 ☐ Yes 2 ☑ No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21703 593 Cawley Drive, Unit 1A Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No World
If Yes, Give
Year or Dates: War I 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: þ White 3 X Widowed 4 □ Divorced War II Completed 16b. Kind of Business/Industry Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Electric Utility Line Manager Electric nd 2 should be filed with and Mental Hygier 27 is marked other the traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Steiffen James J. Smith ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If Item 27 is ury or other trau 2451 Heathervalley Place, Toledo, Ohio 43614 Jim Smith / Son Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Sunset Memorial Park July 8, 2009 North Olmsted, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute Abdomen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached f Ö 9 I Inknown 9 Unknown σ, s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Multiple Myeloma 24b. Were autopsy findings available prior to completion of cause of death? Congestive Heart Failure Pneumonia 24a. Was an certificate has page 2 perform Physician: The 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Directory completely filled in br 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier July 2, 2009 D40307 ayene 30. Name and a press of person who completed puse of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D. 1564 Opossumtown Pike, Frederick, Maryland 21702 32. Regist ar's Signature 31. Date filed (Month, Day, Year) State

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JL

Registrar

09-0503	5
Thomas	Trimble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 219

		1- For State Ce Registrar	ertificate of L	Death			Reg. No.	
Physicia		Decedent's Name (First, Middle,Last)				2. Date of De	ath	3. Time of Death
Mediçal Examir	ner	Thomas Lee Trimble	, Jr.			Month June 26,	Day Year 2009	0104 hrs
		4a. Facility Name (if not institution, give street and number)		. City, Town, or Lo	ocation of Deat	h	4c. County of	Death
		9527 North Laurel Road		Laurel			Howard	
Funeral	П	5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of B	irth(MM/DD/YYYY)	9. Birthplace (State or Foreign Washington ,
Director		577-70-7871 1XM 2 F 56	Yrs.	Months Days	Hours Mir		11,1953	Country) D. C.
	ŀ	Usual Residence of Decedent						
any	ı	10a. State 10b. County 10c. Cit	ty, Town or Location	١				10d. Inside City Limits
	니	Maryland Howard	Laurel					1 X Yes 2 No
nylar Sa-f s	왉	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	it Country?
or 28	Director	9527 North Laurel Road		20723	3	ļ	United	States
vith tl	<u>ह</u>	11. Marital Status 12. Was Decedent Ever in	U.S. 13, Was	Decedent of Hispa	anic Origin? (S	Specify Yes or N		American Indian, Black,
ath v items	Funeral	1 Never Married 2 Married Armed Forces?		, specify Cuban, I			White,	
ter de	리	3 Widowed 4 X Divorced If Yes, Give Year	1□ Y	es 2 X No	specify:		Specify:	Black
us af	흿	or Dates: 15. Decedent's Education (Specify only highest grade completed)		Usual Occupatio		work done	16b. Kind of Busi	
2 hou	촱	Elementary/Secondary (0-12) College (1-4 or 5+)	during mos	t of working life. D	OO NOT use re	tired)		
hin 7	Completed	12th grade	Truck	Driver			Hostess	Cakes Company
d wil	칡	17. Father's Name (First, Middle, Last)		18	3.Mother's Nam	e (First, Middle	Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medic	Be (Thomas Lee Trimble, Sr.			Jean	Delore	es Prout	
21, Muld b Men mar	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	Address (Street a	and Number or	Rural Route No	mber, City or Town,	, State, Zip Code) 20747
MD id 2 shoulth and m 27 is aumatic	Ξí	Janiece Lee Trimble (Daughter)) 6417 н	il Mar D	rive;A	ot.402;	orestvil	le,Maryland
e, land land Health item	- 1		. Place of Disposition	on (Name of ceme	etery,	Date	20c. Location - 0	City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medic-I Examiner must be notified at once.	- 1	1 Burial 2 X Cremation 3 Removal from State	crematory or othe		I	1y 9,20		11. Ya1
it. Purtue	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee/	hesapeake	me and Address o	ory, In	C. Hori	Beltsvi	11e,Maryland ny Morticians,
Ba Derm Imp	- 1	Handala Col Hard						ington,D.C.200
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the dea	th. Do not enter the	mode of dying, si	uch as cardiac	or respiratory a	rrest, shock, or hear	t Approximate Interval
/ 'ledical		failure. List only one cause on each line.						Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Methadone in Due to (or as a consequence		n and co	caine	use		_
	- 1	h	,-					
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):					
	Examine	C. (Disease or Injury that initiated control to the	-0-			-		
ed nsit	%	events resulting in death) Last Due to (or as a consequence	or):					
3760, ficate be executed g physician and s the burial - transit		X UNPENDED X AMENDED 23a,2/	,28a-1, p	er ME g8	393 7/1	4/09 TT		
O, e be e sicia buria	ë	#1 as n	otea					
8760, ificate be ag physicist the burnist the burning	뒴	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre		Ideath 3	Ectopic prear	nancv	23d. Date of d Month	Day Year
Box 687 e death certific the attending ged for use as the	Physicia	past 12 months? 4 Pregnant at time of	-I I	r (Specify)		,	9	,
Boy e death the att	Ş	1 Yes 2 No 9 Unknown g Unknown						
at the		Part II. Other significant conditions contributing to death but no	t resulting in the und	derlying cause giv	en in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?
P.O.	힐					1 _ Y	es 2 No 3	Probably 4 🗸 Unknown
ords, w requir	Completed					24a. Wa		ere autopsy findings available
COI law law e 2 sł	립	· · · · · · · · · · · · · · · · · · ·				per	ormed? de	ior to completion of cause of eath?
tal Rectian: The certificate ector, page	Ŝ.				(D (O)		2 V No 1	Yes 2 No
ician ician s certi	a	25. Was case referred to medical examiner?	ED/Outrotions		of Death (Check	ing Home 5	Residence 6	Other: Soons
f V.	유	1 Yes 2 No	ER/Outpatient 28b. Time of Inju	0 000	INGIS		how injury occurre	
n of ding Ph	티	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	200. Time of my		es 2 X No	unk	s now injury occurre	<u> </u>
Sior Attend death cctor:	哥	2 Accident Investigation Fd 6/26/09) aф		- 111	/O+	Desta Number Oite
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been silted in by the funeral director, page 2 should b	Certification:	3 Suicide 6 X Could not be determined (Specify)	house	factory, office bui	ilding, etc.	28f. Location	State 9527 N	r or Rural Route Number City Laure L Rd
spita hours neral	8	4 Homicide				1		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ह	Control Certifying Physician: To the best of my knowledge one) Wedical Examiner: On the basis of examination						
To the within 2 To the complet	Medical	and manner stated.	. and/or investigatio			at the time, uat		
	≥	29b. Signature and title of certifier		29c. License				d (Month, Day, Year)
		West 2		O.C.M	.∟.		June 26, 20	U 9
,	İ	30. Name and address of person who completed cause of death (Ite			LID CIS	.4		
L		Ana Rubio MD. Assistant Medical Examiner	111 Penn St	reet, Baltimor	e, MD 2120	J1		
	ate		ature					
Regist	0:10							i i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED, #10c = For State Registrar FH, TCHD, 6/23/09, RK Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 JUNE 20. 0800 A^M GEORGE ROBERT TARR, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CAROLINE CAROLINE HOSPICE DENTON | If Under 24 Hrs. | 8. Date of Birth (Month, Day, DEC 20, Birthplace (State or Foreign Country) ___ 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days XXM 2 F 91 MD Director 218-03-2983 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. Cify, Town or Location 10a. State 10h County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes XX No Director ROYAL OAK St.Michaels MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25847 ROYAL OAK RD. 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★★ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Types 2 No fives, Give Year or Dates: 1941-1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes XX No Specify: Specify: WHITE Completed by **3** ¥Widowed 4 □ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN RESIDENTIAL other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be GEORGE MARION TARR JR MABEL M. JONES ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health a MARY ANN SMITH DAUGHTER 28985 SANDERSTOWN RD. TRAPPE, MD 21673 other 20c. Location - City or Town, State 20a. Method of Disposition Date Place of Disposition (Name of cemetery, crematory or other place) 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMETERY 06-25-2009 ST. MICHAELS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERCEROR JOHN K. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OMONGHI **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) HospItal or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ 6 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No 2 🔀 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 TOther (Specify) NOSDICE 1 Tes 2 SatNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

filled in by the 24 hours a

6RK

within 2

State Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

in

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 6 22

Location (Street and Number or Rural Route Number, City or Town, State)

98 Cymbood Drive, Ste. 104

Easton, MD

MO

	1 - State of Maryland / Depart Registrar Certification	ment of Health and M ficate of Death	ental Hygiene Reg. No. 2 () () 9 2 9 7 5
Physician	Decedent's Name (First, Middle, Last) Jean Elizabeth Thomas		2. Date of Death Month Day Year June 30, 2009 3. Time of Death 8:20 A M
/Medical Examiner Funeral	4a. Facility Name (If not institution, give street and number) Genesis ElderCare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	b. City, Town, or Location of Death La Plata f Under 1 Year If Under 24 Hrs.	4c. County of Death Charles 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	220-62-5010 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati		January 3, 1953 Country) Maryland 10d. Inside City Limits
or 28a-f sho	Maryland St. Mary's	Great Mills 10f. Zip Code	1 ☐ Yes 2 ☑ No
hours after death with the Maryland tural", or items 23a or 28a-f show at Exartive riust be notified at ed by Funeral Director	45935 Fox Chase Drive Apt.1004	20634 s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto F	usa cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
"natural", or it	3 ☐ Widowed 4 ★ Divorced Year or Dates: 15. Decedent's Education 16a. Deceden	Yes 2 No Specify:	Specify: White 16b. Kind of Business/Industry
filed within 72 hou Hygiene. Whyliene wither than "natura ent, the Mudical E Completed	Elementary/Secondary (0-12) College (1-4or 5+)	d of work done during most of workin NOT use retired) Homemaker	Own Home (First, Middle, Maiden Surname)
should be fill and Mental H s marked oth umatic even	17. Father's Name (First, Middle, Last) James Bruce Thomas, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing A	ŀ	Aary Ethel Ellis I Route Number, City or Town, State, Zip Code)
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'naturany injury or other traumatic event, the Involced once. To Be Completed	Tammy Goldsborough / Daughter P.O. 20a. Method of Disposition 1 □ Burial 2 ☆ Cremation 3 □ Removal from State 20b. Place of Disposition cermetery, cremative	Box 233 Lovevil	L1e, MD 20656 ate 20c. Location - City or Town, State
permit. Par Departme Important any injury	Mat	lame and Address of Facility tringley-Gardiner Fun b. Box 270 Leonardto	eral Home, P.A.
rificate be executed by trificate be executed as the burial-transit as the burial-transi	23a. Part L. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death O
hat the death certified by the aftending pletached for use as Physician/Mec		ctopic pregnancy ther (specify)	23d. Date of delivery Month Day Year
en signed that all be deta	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓ Unknown
:: The law requil			24a. Was an autopsy performed? 1 \[\text{Yes} \] 2 t \[\text{No} \] 24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 t \[\text{No} \]
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Physician/Me	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		a (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
tal or Attending F rs after death. al Director: After led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
o the Hospi ithin 24 hou the Funer ompletely fill	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invessand in anner stated.	stigation, in my opinion, death occurr	ed at the time, date and place, and due to the cause(s)
To with To COIT	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	29c. License number	29d. Date signed (Month, Day, Year)
State	31. Date filed (Month Day, Year) 32. Negistrar's Signature	MD. WALD	ory MN 20603
Registrar	I WE U.Z. (UUS LA COMPA) M. APA	A STATE OF THE PARTY OF THE PAR	

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			For State	State	of Mary		partment of Fertificate of		and Mental I		2000	21076
			Registrar 1. Decedent's Name (First, Middle	a Last)			erimodio or		2. Date of	Reg. N	(A) (1 (1) (1)	3. Time of Death
	Physicia			i Vero					Month	D	2009 Year	3:47 A M
	/Medic		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location of	June f Death		c. County of Dea	
	Examin	er	Kline Hospice H	-			Mt Airy			F	rederic	ζ.
	Funeral		5. Social Security Number	6. Sex	7. Age (li	n yrs. last birtho	ay) If Under 1 Year	If Under 2	24 Hrs. 8. Date of	Birth , Day, Yea	9. Bi	rthplace (State or Foreign ountry)
	Director		064-34-0091	1 ∑ M 2□F		66 Yrs	Months Days	Hours	Min. (Month	29.	1942 Nev	
3	p .		Usual Residence of Decedent		10	c. City, Town o	- Landian					10d. Inside City Limits
-	show	<u>_</u>	MD Freder	cick		rederic						14 Yes 2 □ No
	8a-f	ect					10f. Zip Code			10g (Citizen of What C	
4	Mith t	ä	10e. Street and Number							US		outiny i
-	sath v	Funeral Director	1128 Young Place		cedent Eve	rinllS	21702 3. Was Decedent of F	Hispanic Orio	nin? (Specify Yes o		14. Race - Am	erican Indian,
_	item	ᇤ	11. Marital Status1 ☐ Never Married 2 ☒ Marr	Armed	Forces?	1110.01	If Yes, specify Cub	an, Mexican,	, Puerto Rican, etc.)	Black, Whi	te, etc.
2-003a	al", or	þ	3 ☐ Widowed 4 ☐ Divorced	It Vac (Give Dates: 19	61-64	1 □Yes 2 🔯 No	Specify:			Specify: Wh	ite
ָבָּ בְּ	2 hou	Completed	15. Deceden	t's Education		16a. D	ecedent's Usual Occu	oation	of working	16b.	Kind of Business	
7	as e	ηple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	- li	fe. DO NOT use retire	d)	or working		4	
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<u> </u>	Men Men arke	ပ္	Richard Whitman		iburg_			L	fred Camp			
Mar	2 sh h and ris m raum		19a. Informant's Name/Relations Barbara A. Vero				lailing Address <i>(Stree</i>)					Zip Code)
a) .	Tand Health		20a, Method of Disposition	J/ WITE					Date		Location - City o	r Town, State
ב פ	nt of I		1 ☐ Burial 2 🖫 Cremation		m State	cemetery,	isposition (Name of crematory or other plate of courney Cre	ce) ;		1	•	
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g	permit. Pages 1 and 2 should be liled within 7/2 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evandaria in the multified at once.		21. Signature of Funeral Service	Licensee / JA	N	101251	Going Home	Crema	ation Ser	Vice	P.O. B	le, MD 21029
		\vdash	23a, Part 1, Enter the disease, or	complications tha							Larksvii	Approximate
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oʻ !	e exe ian aı ırial-t		resulting in death) Last	Due 1	to (or as a co	onsequence of)						
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9	certific nding p use as t	Mec	IF FEMALE:									
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. 3	the de by the a	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Ur	egnant at tin nknown	ne or death	5 ☐ Other (specify)					
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Records	The law ate has b	E G						_		autopsy performed es 2 1	prior t	o completion of cause of
	in: T tifficat or, pa		25. Was case referred to medica	ı T				26 Place	1 □ Y of Death (Check of		No 1 1 Y	es 2 No
	ipital or Attending Physician: The law nors after dearbase. After this certificate has filled in by the funeral director, page 2.9	o Be	examiner? 1 ☐ Yes 2 🛣 No	Hoonital	☐ Inpatient	2 ☐ ER/Outp	atient 3 □ DOA Ot		ursing Home 5		6 Other (Si	pecify) hospice
ō	g Phy erthi eral d	n: To	27. Manner of Death	28a. Da	te of Injury	28b. Tir	ne of 28c. Inju				njury occurred	
DIVISION	ndin ath. r: Aft e fun	atio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ig .	onui, Day, i	ear) Inju		Yes 2□	No			
SIN	ol or Attending F after death. I Director: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 28e. Pla	ce of Injury	- At home, farm 'Specify)	, street, factory, office		28f. Locat	on (Street r Town, St	t and Number or tate)	Rural Route Number,
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1	14									54	25, 2	
12	2/10		30. Name and address of person	·)γ- T:	odori di	MID 3	1702	
	Sta	te.	Sebastien Kair 31. Date filed (Month, Day, Year,	32	. Degistrar's	Signature		ντ• <u>Γ</u> Γ	euer ICK,	2 تيت	1702	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Ethel R. Wimberly June 2009 3:35p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Director 58 March 18,1951 Virginia 218-54-7434 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a State 10b. County event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 28a-f Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 116 Crosstimber Way 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than any Injury or other traumatic event, In. M. Elementary/Secondary (0-12) College (1-4or 5+) Medical_Biller <u>AHMA Medical</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leona K. Jones <u>Jasper James Davidson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hashmall/ Daughter 903 Horizon Road, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify)Entombment Mt. Oxivet Cemetery 6/22/2009 Frederick, Maryland 21. Signature of Theral Service Licenses Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Non Small Cell Lung Cancer 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) o the 9 Unknown s been signed by t should be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy or Attending Physician: The performe certificate 1 □ Yes 2 No 2**/2** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Map fer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature

10

State

Registrar

Farrell MD 9707 Medical Center Drive, # 300 Rockville Maryland 20850 31. Date filed (Month, Day, Year) JUN 2 4 2009

Nicholas

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D67258

June 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009^{Year} Day JULY Month **Physician** HENRY ROBERT 3 9:15 ам WALKER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 29 Park Lane Earleville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 13 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months 1 XM 2 □ F 1924 Delaware 85 222-10-8123 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be recitled at 1 ☐ Yes 2 XNo Director Earleville MD Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29 Park Lane 21919 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XiYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White Saltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify Specify. 2 3 ☐ Widowed 4 ☐ Divorced 1943 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 10 College (1-4or 5+) Chemical Manufacturer Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard B. Walker Priscilla Phillips ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important; If item 27 is n any injury or other traur 29 Park Lane Earleville, MD. 21919 Lillian S. Walker (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stephen's Cem. 7/7/09 Earleville, MD. 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 23a. Partie Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) pestive **Physician** 02 /Medical Due to (or as a consequence of): Examiner hemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and 0 nah the burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No Month 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 fres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

State Registrar

24 hours a

completely To the l within 2

29a. Certifier

29b. Signature and title of certifie

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Bruce Obenshain, M.D. 32. Registrar's Signature

251 S. Bohemia Ave. Cecilton, MD. 21913

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4:50 4 M ALEXANDRIS UNDA 2009 JULY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAYVIEW JOHNS HOPKINS BAYVIEW -Morre 8. Date of Birth (Month, Day, Year) April 9, 1954 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Maryland 1 ☐ M 2 🗹 F 213-66-8791 55 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 21 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Fallston Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 2108 Folkstone Drive 21047 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Collection State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Robert Rollins Helen McLemore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Mitchell Alexandris Spouse 2108 Folkstone Drive Fallston, Md. 21047 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-10-2009 Fallston, Md. Highview Memorial 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Prit1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician persistent injection month disease or condition resulting in death) /Medical o (or as a consequence of): dependence Examiner CINTONIC ventilativ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit quadripleg1a Due to (or as a consequence of): cerncomedulary hemorrhage Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ₩No 4 ☐ Pregnant at time of death 5 Other (specify) <u>Р</u> О. a 🗆 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, syndrome Antibod phuspholipid 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 ☐ No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M D RES - 000 Ü

State Registrar

DHMH 17 Rev 1/2001

JUL 1 0 2009

31. Date filed (Month, Day, Year)

BAYVIEW 4940 EASTERN AVENUE

BALTIMORE 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII & 25 per ME 9893 7/8/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician p^{M} 06 30 2009 01:25 Mary Alatzas Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Riverview Nursing Home 8. Date of Birth (Month, Day, Yeer) 12/07/1917 Birthplace (State or Foreign Country)
 Pennsylvania If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 🗓 F Director 213-10-0613 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ent: If Item 27 is marked other than "netural", or Items 23e or 28e-f show ent: If Item 27 is marked other than "netural", or her must be notified at ury or other traumatic event, Item Medical Exprime must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 U.S.A. 1 Weyburn Court Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 [X] If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Magnas James H. Tangires ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Weyburn Court Baltimore, MD 21237 Evangeline Y. Frangos, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or St. Demetrios 07/03/2009 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) Leonard J. Ruck. Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 lesandue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thero Physician 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION AS FROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Be Completed by Physician/Medical Examiner death certificate be executed Due to (or as a consequence of) Box 68760, the l attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached o 9 Unknown The law requires that the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Demontia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should houlder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ze_(/n 2□ No due to severe osteoporosis 25 No 1 TYes Division of Vital or Attending Physician: in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel & completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASECM 709, EASTERM M.D - 21221 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Degdent's Name (First, Middle, Last) 2. Date of Death **Physician** Jest 0400 9170 /Medical 4a Facility Name (If not institution, give street and number) Town, or Location of Death County of Death **Examiner** Care SIG HOLESP J If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F Yrs 72 **Director** 183-28-0619 10/14/1936 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mudical Exercitive coust be potified at Funeral Director 1 XYes 2 No MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 5 23a 6799 Hickory Ridge Road Apt #307 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Completed by White Specify: 3 ☐ Widowed 4 🎖 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Front Desk Manager/Hotel Hospitality 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental I John ဥ Zimmer Winifred 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Lisa Kelly/Daughter 6814 Roslyn Court, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4
☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 7/9/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the papel of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 ÛNo 24b. Were autopsy findings available prior to completion of cause of death? this certificate 2 🗆 No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4. Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/2/Natural 5 Pending investigation Injury death 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Mary Elizabeth Allen 8:30 2009 July 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🔀 F 2-4-1913 MD Director 96 220-30-0869 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Experience count be notified at 10a. State 1 ☐ **W**es 2 ☐ No Director Baltimore Edgemere MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21219 2825 Lodge Farm Road, Apt. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No Specify Specify: \$ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 <u>Homemaker</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Stallings Edwin Wright ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9000 Kilbride Road, Perry Hall, MD 21236 <u> Joseph E. Lawrence - Son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 7-7-09 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 21. Signature of Funeral Service I Bradley-Ashton Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nonns which disease or condition resulting in death) /Medical Du lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) NW S QUE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1💌 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHALLES M 670

29d. Date signed (Month, Day, Year)

Charles ST

h, Day, Year) 31. Date filed (Month,

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day

3 Time of Death

Physician /Medical Examiner

1 - For State Registrar

Director Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examinar must be notified at

Maryland

Physician /Medical Examiner

permit. Page: Department o Important: If I any Injury or

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the houreal director, page 2 should be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

10:50 A.M Alvin D. Alger 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE HUSDITAL GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 – 2 – 1935 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**⊠**M 2□ F 74 MD 213-32-2824 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c City Town or Location 10b County Director Baltimore City 1 XYes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2804 Halcyon Avenue 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 □¥es 2 □ No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔼 No Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private School 12 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Broyles John Alger ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1366 Kenton Road, Baltimore, MD 21234 Mary Kline - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-13-09 Rosedale, MD Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licensee 21222 PA, 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERG CARDIOMYO PATHY disease or condition resulting in death) Due to (or as a consequence of): MYOCARDIAZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ CANCER Completed 1 PYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ATTENDING DAYSUAN DODGOOSS. July 8 MAN NOO,MD HOSPITAL, BATTIMORE 20062239 2009. 30. Name and address 🔲 7 n who completed cause of death (Item 23a) (Type, Print) SAMARITAN 31. Date filed (Month, Day, Year) State

XI

Registrar

JUL 1 0 2009

			For State Registrar	State of Ma		ertificate of		wentar riy	Reg. No	2000	21984	
	Physici	an	1. Decedent's Name (First, Middle, Las Clothie	Marie	Веу			2. Date of De July		009 Year	3. Time of Death 11:22 AM	
-	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat			County of Death		
_	L-Adiiiii	C.	Prince George's	,	spital		Cheverly Prince Geo					
	Funeral Director		5. Social Security Number 426–76–1394 6. Security Number 426–76–1394		(In yrs. last birthda 73 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth a <i>y, Year)</i> 7 , 19	9. Birth Con Mis	place (State or Foreign intry) SISSIPPI	
	yland		10a. State 10b. County	1	10c. City, Town or						10d. Inside City Limits	
	e Mar Ba-f si	ctor	MD Prince G	eorge's	Seat Ple						1x Yes 2 No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Experiment must be redified at	Funeral Director	5700 Addison Roa			10f. Zip Code 20743	-		US			
	items iner	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🖾 No	ver in U.S.	B. Was Decedent of I If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	D-	14. Race - Amer Black, White		
036	al', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify: B	lack	
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Baltimore,	Pages ment of lant: If ite		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			tine Ceme			-	lorsvil	le, MS	
Balt	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licens	ndOl		22. Name and Addre Cound Fune				Street 111e, MS	39168	
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-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. MALIGI	NENT C	KDIAC	AKKHY	THU14			Grider and Boarn	
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	ertifica ing ph e as th	Medical	IF FEMALE:									
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	ry - At home, farm, s (Specify)	street, factory, office	1103 2 2 110	28f. Location City or To			ral Route Number,	
_	Hospital 24 hours Funeral stely filled	Medical Co	29a. Certifier (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner stat	examination and/or	investigation in my	opinion death occ	urrad at the time	data an	out bas and due	to the cause(s)	
	To the vithin To the comple	Med	29b. Signature and title of certifier	and manner state	ed.	29c. Licens	se number		29d. Da	te signed (Month	, Day, Year)	
			1) =			D5818	2		1-2-	09	
l	10V		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type	e, Print) HOSPITA	AL DRIV	E CA	EVE	RLY, MI	Day, Year) 09 1. 20785	
_			31. Date filed (Month, Day, Year)	11	0-0							

Patient Known as: Carol Balker Balter Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

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Physicia /Medic	al	Carol	H.	Bak	er	4h Cihi Toura o	r Logation of Do	100	9 1	200 9 ounty of Death	2205™
Examin	er	4a. Facility Name (If not institution	11 1	D 11.	nore	4b. City, Town, of	timore	City	40.00	ounty of Death	
Funeral Director		5. Social Security Number 217–72–0858	6. Sex 1 M 2 AF	ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)	9. Birthp Cour	place (State or Foreign ntry) DC
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ns 23a must	Funeral	4617 WHEELER 11. Marital Status	12. Was Deceden	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba		(Specify Yes or N		JSA . Race - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important: If item 27 is marked other than "natura"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 XNever Married 2 Mar 3 Widowed 4 Divorced	Armed Forces 1 Yes 2	?		Yes, specify Cuba	an', Mexican', Pu Specify:	èrio Rican, etc.)		Black, White, Wh:	etc. ite ACK-
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d Meni marked matic e	2	KENNETH BAKER 19a. Informant's Name/Relations	chin (Time Print)		10h Mailin	g Address (Street	•	UELINE W		Town State 7ii	n Code)
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permi Depar Impo any Ir		21. Signature of Funeral Service	CI M	to	ļ	701–31 L			TIMORE		21217
Physician Medical Examiner popularitansit	cal Examiner	23a. Part lenter the disease, o sh sh, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequen	ce of): ce of):	er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 Fetal de at time of deat	ath 3	Ectopic pregnancy	у		23	d. Date of deliv	very Day Year
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or Attend ifter death Director: / in by the f	Certification:	3 Suicide 6 Could	minor Zoe. Flace of II	njury - At home etc. <i>(Specify)</i>	, farm, str	M	Yes 2 ☐ No	28f. Location City or T	(Street and own, State)	Number or Rui	ral Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical Ce	29a. Certifier 1 Certifyl (Check only one) 2 Medica	Ing Physician: To the besing Examiner: On the basis and manner s	of examination	dge, death and/or in	n occurred at the ti vestigation, in my o	me, date and pl opinion, death o	ace, and due to the	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s)
To the Within To the compl	Me	29b. Signature and title of certific		en	~ ~~	29c. Licens	se number	9	29d. Date	signed (Month	, Day, Year)
21		30. Name and address of person	n who completed cause of	death (Item 23	Ba) (Type,		Das	- Off	100	d W	1 de Cinn
Sta	te.	31. Date filed (Month, Day, Year	r) 32. Regis	trar's Signatur	ハノ	15	105		49	1	70602
Registr		JUL 1 0 2009	Benevat.	B. 400	ale						2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:354 Francis Bund 2009 ward 07 07 /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ivy Hall Genutric Middle RIV Bultomore 4 nter If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days †₩ M 2□ F 82 220-14-8523 12-12-1926 NEW JERSEY Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD BALTIMORE ROSEDALE 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1209 62nd STREET 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 126/es 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: δ ¾ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 1 2 College (1-4or 5+) GENERAL CONSTRUCTION the PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked othwany injury or other traumatic event Be (WHITTEN) **EDWARD** F. BOND, SR. ADA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 SEAFARER LANE BERLIN, MD JOHN BOND/BROTHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-10-09 GARDENS OF FAITH BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL ROME Service Licensee 21. Signature 21237 1211 CHESACO AVE ROSEDALE, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Uss tructive PHLMONARY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

(hukwuma

31. Date filed (Month, Day, Year)

Chuks Das.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue, Buetimore, M.D. 21221 1124 Mace 32. Registrar's Signature

D0061907

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Ann Bostek Ethel A M 1:05 July 9, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 483 Glen Mar Circle, Apt A3 Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-12-1930 9. Birthplace (State or Foreign Country) New Jersey 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Months Hours Min. 79 137-24-2700 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.

ant: If Item X7 Is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, it. Medical Exprise it as to northful any or other traumatic event, it. Medical Exprise it as to northful. 1 TYes 2 □ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 483 Glen Mar Circle, Apt A3 21061 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unavailable <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unavailable unavailable ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arayna Lambardi - Guardian 466 Glen Mar Road, B2, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o Burial 2 Cremation 3 Removal from State Bayview Mem. park Pensacola, Florida 07-15-09 4 ☐ Donation 5 ☐ Other (Specify) M00053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licenses Mark M. Broka MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacl, line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Box 68760, Hospital or Attending Physician: The law requires that the death certificate be by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 1 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, To the Funeral Director: completely filled in by the 24 hours a within 2

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

SRIDHAR ATLURI

RITCHIE

and manner stated

8109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ASADENA :

HIBHWAY

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25,27, & 28a-f, perME, G893, 7/10/09 TT

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** PM ne 2009 une /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner timal 70 If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Months Days Min 216-54-249 Hours 1 M 2 □ F Yrs Mary land Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating must be notified at 1 Nes 2 No Director altimor 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 \(\text{Yes} \) 2 \(\text{NM} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □M6 Black If Yes, Give Year or Dates Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) sable h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be exande ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) sathmore. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 109 5 ☐ Other (Specify) 4 Donation Fineral Service Licen 22. Name and Address Facility - mo 21. Signature Balto MD21201 Ave Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con ence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER ng physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the attending IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 Ectopic pregnancy for Month Year 5 ☐ Other (specify) detached ☐Yes 2☐No o 9 Unknown 9 Unknown ₫. ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I. Records, ð 1 Tes 2 🔲 No 3 Probably Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an av has p∘ge 2 s autopsy he certificale 1 □Yes of Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes -2 7Nc 1 patient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division Injury subject slipped on ice 5 Pendina 1 ☐ Yes 2 🛂 No after death. 2 XAccident investigation 4, 2009 unk and fell completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1900 Blk. Saragtoga 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide St. Baltimore, MD within 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day, Registrar's Year, State 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 1:25 A M **Physician** Nilliam 2009 July 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 11.27.1949 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 □ F 59 MD 219.50.3001 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Baltimore Director MD Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21222 7001 Railway Avenue Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: δ Vietnam White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) <u>Military</u> Armed Forces 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Orlando William Batton Margaret G. Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jim Batton/Brother 6913 Norman Avenue Balto., MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 07.09.09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final herniation a brain **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury Examine requires that the death certificate be executed attending physician and 1 for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No by the of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed certificate 26. Place of Death (Check onl one 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this completely filled in by the funeral 28a. Cate of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: (Month, Day Year) 5 Pending investigation or Attending 1 Tes 2 No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division

State Registrar 29b. Signature and title of certifier

Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number RES OOC 29d. Date signed (Month, Day, Year)

07-06-09

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \ igcap \ igcap$ Certificate of Death

Physicia /Medic Examin

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if e Mariet Examirer must be multified anone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

-	1. Decedent's Name (First, Middle, L	•				2. Date of Deatl Month	Day	Year	3. Time of Death		
ı	Catherine Marg					July	5 20		1:42p M		
ı	4a. Facility Name (If not institution, g			1	r Location of Death		4c. County				
	Carroll Hospita			Westmi:		place (Ctate or Fareign					
	5. Social Security Number 6. 213–20–9450	Sex 7. Age (In your 1	rs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 23	^{Year)} 1918	Go.	place (State or Foreign intry) MD		
- 1-	Usual Residence of Decedent		City Town on I	Location					10d. Inside City Limits		
- 1	10a. State 10b. County Carrol		City, Town or I Westm	inster					1 □Yes 2 No		
ŀ	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	intry?		
١	3816 Ridge Road			2115	7		USA				
	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 U.S. 13	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 1 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Bla	ce - American Indian, ack, White, etc. f/:white			
	15. Decedent's		16a. Dec	cedent's Usual Occur	oation		16b. Kind of E	Business/I	ndustry		
1	(Specify only highest of	grade completed)	1 (Gir	ve kind of work done . DO NOT use retire	during most of work	-		1			
1	Elementary/Secondary (0-12) Q	College (1-4or 5+)	sal	es clerk			retail	sale	es		
ŀ	17. Father's Name (First, Middle, La.	st)			18. Mother's Nam	ne (First, Middle, I	Maiden Surna	me)			
1	Charles L. Fra				Carrie Claggett						
-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										
	Susan Ettlin (tr			lcon Ct.,					,		
Ì	20a. Method of Disposition	•	i				20c. Location		Fown, State		
	1 Deurial 2 Cremation 3	☐ Removal from State	cemetery, c	position (Name of rematory or other pla	ce) 7. O	00	Sykesv	1110	MD		
	4 □ Donation 5 □ Other (Spec	*/		eld Cemet		l l	-				
	21. Signature of Funeral Service Lic			22. Name and Address P.O. Box					& Chaper		
1	23a, Part 1. Enter the disease, or co	mplications that caused the d	-						Approximate		
1	shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.		,	0.				Interval Between Onset and Death		
disease or condition resulting in death) a. Due to (or as a consequence of):											
1	resulting in death)	Due to (or as a cons	sequence of):					- 1			
Sequentially list conditions, b.											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)											
	that initiated events	C									
1	resulting in death) Last	Due to (or as a cons	sequence of):								
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7							-	-			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			ate of del Month	ivery Day Year		
f	9 Unknown	9 ☐ Unknown									
	Part II. Other significant condition	s contributing to death but not	resulting in the	a underlying cause gi	ven in Part I.				the cause of death?		
	COPD DAM	entiq				1 □ Y	es 2□No	3 □ Pi	obably 4 🗹 Unknow		
						24a. Was a	n 24	. Were a	itopsy findings available		
		· · · · · · · · · · · · · · · · · · ·				autop:	sy med?	prior to death?	completion of cause of		
						1 ☐ Yes	2 🗹 No		2 □No		
	25. Was case referred to medical examiner?	Hoopite!:		100		ath (Check only or	ne)				
	1 Yes 2 No			tient 3 1 DOA		Home 5 Resid			cify)		
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investiga	28a. Date of Injury (Month, Day, Yea. tion	r) 28b. Time Injur	y Wa	uryat urk? ⊒Yes 2 ☐No	28d. Describe h	ow injury occi	urred			
	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, pecify)	street, factory, office		28f. Location (S City or Tow	treet and Nur n, State)	mber or R	ural Route Number,		
modular con mineral con	29a. Certifier (Check only one) 12 Certifying 2 Medical Ex	Physician: To the best of my xaminer: On the basis of examand manner stated.	knowledge, de mination and/o	eath occurred at the or investigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner a e, and due	s stated. e to the cause(s)		
2	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date sign	ned (Mont	h, Day, Year)		
	B 0 0 1	C to	2	H 53	939		7/21	2009			
	ruan m	rema 10	<u>ں</u>		1		1 - 1				
	30. Name and address of person w Babak Imaneel,	Do : 218 washi	ngton		el Ctro we	estminste	r, Mi	0 2	1157		
	31. Date filed (Month, Day, Year)	2009 Leneur	ignature	-							
	JUL I ()	ZIIII Deneur	1 4.	Barre							

St

			1 - State Registrar		C	ertificate	of Dea	th	F	Reg. No.	uug	- 1	99
	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month	Day	Year	3. Time of	
-	/Media		Norman Edward						July	8	2009	6:45	A M
	Examin	er	4a. Facility Name (If not institution, gi 2525 Pot Spring		- 333 VI	4b. City, Tov	vn, or Locati I onium	on of Death		4c. Cou	unty of Death Baltin	nore	
	Funeral				e (In vrs. last birtho			der 24 Hrs.	8. Date of Birtl	h	9. Birthr	place (State o	or Foreian
	Director			1 🔀 M 2□ F	80 Yrs	Months D	ays Hou	rs Min.	July 14	v, Year)	Coui	yland	
	yland how		10a. State 10b. County	_	10c. City, Town o						1	0d. Inside C	ity Limits
	e Mar	cto	Maryland Balt	imore	Tim	onium						1 ☐ Yes	2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar mast be rediffied at once.	Completed by Funeral Director	10e. Street and Number 2525 Pot Spring	Road, Uni	t 333 AL	10f. Zip Co 21	^{de} 093		10g. Citizen of What Country U.S.A.			itry?	
	tems	nuel	11. Marital Status	12. Was Decedent B Armed Forces?		3. Was Deceden	t of Hispanic Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	lo	1 □ Yes 2 🔀	No Spec	cify:		Spe	_{ecify:} Whi	te	
9-10	2 hou latura ical E	ted	15. Decedent's E	ducation	16a. De	ecedent's Usual C	ccupation			16b. Kind o	of Business/In-	dustry	
21	ithin 7 ne. nan "n	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	+)	live kind of work a fe. DO NOT use r	one during r etired)	nost of workii	ng		ation/		
121	led wi	S	A T T I A A A A A A A A A A A A A A A A	5	T	eacher	1,0,11		/F: A4: 1.11		ty Publ	ic Sci	nools
Maryland 21215-0036	ould be fi Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Las Edward J. Ba	rczak				Estell	e C.	Tobat	name)		
Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship			ailing Address (S							21020
e,	is 1 and 2 of Health a item 27 Is.		Stephanie B. Do 20a. Method of Disposition	ason / Daug	20b. Place of Di	Dulaney	of.		oate		on - City or To		21030
Baltimore,	Pages ment of h ant: If ite ury or ol		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Most Ho	ly Redee	mer	1	3/2009		imore,		and
Balt	permit. Depart Import any Inj once.		21. Signatur of uneral Service Lice	nsee	\mathcal{L}	22. Name and A		110	ck Tows owson,			lome,	Inc.
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused	the death. Do not							Approximat Interval Bet	te tween
-	Physician		Immediate Cause (Final disease or condition		naest	WE	Hea	1xt	Failu	re		Onset and	
	/Medical Examiner		resulting in death)	и.	a consequence of):	Λ		\sim				1100	1181->
	Examilier	١,	Sequentially list conditions,	U	onary	Hr-	rery	וע	sease	2		yeur	2
	rted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of)					,	
,	execu n and al-trai	Examiner	that initiated events resulting in death) Last	C Due to (or as a	a consequence of):								
68760,	eath certificate be executed attending physician and for use as the burial-transit		(d									
9	rtifica ng ph as th	Medical	IF FEMALE:										
Вох	0 2 8		23b. Was decedent pregnant in the past 12 months?		2 ∐ Fetal death	3 ☐ Ectopic preg	nancy			23d.	Date of delive		Voor
P.O.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	ysician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specif	fy)				Month	Day	Year
	that the de	/ Phy	Part II. Other significant conditions	contributing to death bu	it not resulting in th	e underlying caus	e given in Pa	art I.	23e. Did to	bacco use o	contribute to the	ne cause of c	death?
Records,	quires in sign	Completed by							1 □ Y	es 2 x ∑N	lo 3 Prot	oably 4 🔲 🤇	Unknown
ပ္ပ	aw requir is been s 2 should	olete							24a. Was a		4b. Were auto	psy findings	available
	The law ate has bage 2 s	mo							autop: perfor	sv	prior to co death? 1 ☐ Yes	mpletion of c	ause of
/ita	sician: The certificate h rector, page	Be C	25. Was case referred to medical examiner?				26. PI	lace of Death	(Check only or		1 1 1 1 6 3	١١٠٥	
<u></u>	Physic this c		1 Yes 2 No	ALCO DE LA COLONIA DE LA COLON	nt 2 ☐ ER/Outpa			Nursing Hor	me 5 🗆 Resid	ence 6 🗷	Other (Specif	ssiste a	Civin
Division of Vital	ing l	ioi:	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injui (Month, Day	y 28b. Tim (<i>Year</i>) lnju	y	Injury at Work?		28d. Describe h	ow injury oc	curred		
S	Vittend death ctor: ,	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 Place of Injur	ry - At home, farm,	M street factory of	1 □ Yes 2		28f. Location (S	troot and N	umber or Pum	ol Pouto Nun	nhor
<u>≤</u> .	al or A after Dire d in b	Certification: To	4 ☐ Homicide determined	building, etc	. (Specify)	on out, tactory, on			City or Tow		umber or mure	I House Warr	iber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical (29a. Certifier 1 ✓ Certifying P (Check only one) 2 ☐ Medical Exa	hysiclan: To the best of miner: On the basis of and manner sta	examination and/o	eath occurred at t r investigation, in	he time, date my opinion,	e and place, death occurr	and due to the o	cause(s) and date and pla	d manner as s ice, and due to	tated. the cause(s	s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0 11 Qa	c lat	29c. Li	cense numb	er 7 7 (L	3	29d. Date si	gned (Month,	Day, Year)	00
			30. Name and address of person who				2	- / T	`	70,0	1 8		
			ERNESTINE WRI			DULANEY	VALLE	Y ROAL) BALT	'IMORE	MD	21093	
	Sta Registra		31. Date filed (Month, Day, Year)	2. Registra	r's Signature	a del							
	- registi	41	JUL 1 0 200	y senera	p. 190								

DHMH 17 Rev 1/2001

BARCZAK, NORMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 6, 2009 2:38 P **Physician** Μ. Betancourt Amparo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore 17 Goucher Woods Court Towson
If Under 1 Yea If Under 24 Hrs. 8. Date of Birth (Month, Day, 8/9/1919 9. Birthplace (State or Foreign Country Republic Dominican 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days Min. Hours Months 1 □ M 2 □ F 89 581-61-0543 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" ~-... any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 ☑ No Funeral Director MD Baltimore Towson 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21286 USA 17 Goucher Woods Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2 ∏X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Dominican 1 X Yes 2 □ No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brigida Reyes Luis Maura ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Goucher Woods Court Towson, Maryland 21286 Virginia Padilla / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Serv. Corp. 7/7/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VEAR **Physician** TASTRIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlaf-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) P.O. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2000 certificate 1 Yes 2 No 1 ☐ Yes After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

2352

31. Date filed (Month,

YORK

29b. Signature and title of cert

ROAL . Registrar's Signature

NICKMELLIS MD

of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM

29c. License number

MD 21093

29d. Date signed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Physician YLVIA CARMEL 2009 0.7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE der 1 Year | If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Securify Number **Funeral** Months 1 M 2 F 90 Director 217-01-1249 06/21/1919 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 1 TYes 2 No Director BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 RUTH EAGER COURT 21208 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY SYNAGOGUE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH. SIRULNIK SARAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health as Important: If item 27 is any injury or other trans. 125 RUTH EAGER COURT, BALTIMORE, MD ALAN CARMEL 20a. Method of Disposition

XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) BETH JACOB CONG 07/09/2009 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ERMINAL Physician DEMENTIA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ned by the atter detached for u in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN

State Registrar 31. Date filed (Month, Day, Year)

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE

AJAN1 32. Registrar's Signature

120064533

2434 W. BELVESELE

CIEPIATRIC

BALTIMORE MS21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Virginia Μ. Connors 1:35A^M July 8_ 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis Date of Birth (Month, Day, Year) 12/31/1956 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 X F 52 135-56-9338 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm the digal Evan har a ust be notified at 1 ☐ Yes 2 X No Director PA Carbon Weatherly 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1003A North Street 18255 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Je filed with. *al Hygiene. *r than "r Elementary/Secondary (0-12) College (1-4or 5+) Clerk permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If Item 27 Is marked other 1 any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank E. Connors Arlene Arendt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kasandra M. Smith, Daughter 1906 Jacinto Court, Crofton, MD 21114 aftimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Nicholas Cemetery 07/13/2009 Weatherly, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - Fune al Service Licensee 22. Name and Address of Facility Philip J. Jeffries Funeral Home T.Harman 150 211 First Street, Weatherly, PA 18255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma, Breast **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a P.0. 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐Yes 2 🛛 No 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 🔲 Inpatient 2X ER/Outpatient 3 □ DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Attending 1 XNatural 5 Pending investigation al or Attendir s after death. Il Director: Al 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

29b. Signatury and title of certifier

William P. Jones, MD 695 America Court, 32. Registrar's Signature

death (Item 23a) (Type, Print)

29c. License number

Davidsonville, MD 21035

D06054

29d. Date signed (Month, Day, Year)

July 9, 2009

John Robert Everson 09-05317 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 21995

		1- For State Registrar			Certific	ate of l	Death					Reg. No	D		
Physicia		1. Decedent's Name (First, Middl	e,Last)							2	. Date of De		Van		3. Time of Death
edical Exami	ner	John Robert	Everson								Month July 6, 2	009 Day	Year		1420 hrs
		4a. Facility Name (if not institution	n, give street and	number)	-	4b	. City, Tov	wn, or Lo	ocation of	Death		_	c. County o	Death	
		2320 Glenmont Circle					Silver S	Spring					Montgom	ery	
		5. Social Security Number	6. Sex	7 Age (Ir	n yrs. last bir	rthday)	If Under	1 Vear	If Under	24Hrs	8 Date of F				place (State or
Funeral				, ,	•	iliuay)	Months	Days	Hours	Min.			· · · · · ·	Foreign	1
Director		577-90-6701	1 X M 2 F	4	18	Yrs.		,-			Jan.	9,	1961	MCaus	whington, DC
		Usual Residence of Decedent													
any	10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits			
d How	_	Maryland Mont	romerv		Silve	r Spr	ing								1 X Yes 2 No
Maryland 28a-f show datonce.	ector	10e. Street and Number	5-111-7				10f. Zip C	ode				10g. Ci	itizen of Wh	at Count	try?
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h the	II Dir	2320 Glenmont													
ms ms	Funeral	11. Marital Status	A	ecedent Eve Forces?	er in U.S.						cify Yes or I ican, etc.)	No-	14. Race White		an Indian, Black,
deat r ite	Ë		1 Yes	2 X	No		o, op comy								
after all', c	by F	3 Widowed 4 X Div	orced If Yes, Give Y	/ear		1 1	Yes 2	No	specify:				Specify:	Whi	ite
artur amir	P	15. Decedent's Education (Spe		rade comple	ted) 16a.	Decedent's						16b.	. Kind of Bus	iness/In	dustry
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ther dwir	ő	17. Father's Name (First, Middle	Last)		L						First, Middle		n Surname)		•
1. 15 graph 1. 15	a	John Granville	Everson						Nancy	y An	n Bro	wn			
212 Id be Ment nark	o B	19a. Informant's Name/Relations			110	9h Mailing	Address				and the same		City or Towr	State	Zin Code)
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Baltimore, MD 21215-0036 gemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important of Health and Mental Hygiene Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	20a. Method of Disposition 1 X Burial 2 Cremation	3 Remova	from State		-			etery,		Date	200	. Location =	City of 1	. Own, State
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Dhysisian	_	23a. Part I. Enter the disease, or	complications that		death. Do n	not enter the	mode of	dvina. s	uch as car	rdiac or	respiratory a	arrest. s	hock, or hea	rt 22	Approximate Interval
Physician /Medical		failure. List only one cause	on each line.												Between Onset and
xaminer		Immediate Cause (Final disease				use	comp.	lica	ted 1	by s	ubmer	sior	1		Death
		or condition resulting in death)	Due to (or a	s a consequ	ence of):										
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	ne	if any, leading to immediate cause. Enter Underlying Cause	Due to (or a	s a consequ	ence of):										
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ed nsit	Examine	events resulting in death) Last	Due to (or a	s a consequ	erice orj.										
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of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should I	0	1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/0	Outpatient	3 DO	A C	Other4	Nursing	Home 5	Resi	dence 6	Other:	Scene
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Division of Vital To the Hospital or Attending Physician: within 24 hours after detention. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide		hom hom									ring,		
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orthir orthir ompl	Medical	one) 2 Medical Exa	miner:On the bas and manne		ation and/or	investigatio	ות, וn my c	pinion,	ueath occ	urred at	uie time, da	ite and p	piace, and d	ue to the	s cause(s)
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		30. Name and address of person	who completed a	allee of deal	th (Item 22a)	1									· · · · · · · · · · · · · · · · · · ·
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				-		OIIII	J., 001, 1	- GIGIII	J. J, IVIL						
St Regis	tate	31. Date filed (Month, Day, Year)	2009	R gistrar's	Signature	L	Kel								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11,23 AM 2009 08 Haro1d JULY Edge 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BURNIE ANNE HRUNDEZ BALTIMORE WASHINGTON MEDICAL If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday Months Days 1 XM 2 ☐ F 91 Yrs. England 002-36-7005 08-11-1917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 XNo MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21136 U.S.A. Apt#417 304 Cantata Cre. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify White 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Studdart Samue1 Edge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 566 Essex Road Beaconsfield, QC. H9W3V9 Mr. Dennis Edge / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 07-10-2009 Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licens Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

or Attending Physician: The law requires that the death certificate be execute burial-tran Division of Vital Records, P.O. Box 68760, ${\it S}$ attending physician the the After this certificate has been signed by funeral director, page 2 should be detact death. within 24 hours after death To the Funeral Director: filled in by Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Medical Exeminer must be mutified at

permit. Pages 1 and 2 should be filed within 72 hours after be partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other trainmain.

Physician

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death with the Maryland

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Complete					24a. Was an autopsy performed? death? 1 □Yes 2 ☑No 24b. Were autopsy findings availa prior to completion of cause death? 1 □Yes 2 ☑No	ble of
Ф	25. Was case referred to medical			26. Place of D	eath (Check only one)	_
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ation: 1	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
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lical C					ace, and due to the cause(s) and manner as stated. scurred at the time, date and place, and due to the cause(s)	

29b. Signature and title

29c. License number 29d. Date signed (Month, Day, Year)

D0014147

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 305 Glen Burnice William

and manner stated

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2009 Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2009 **Physician** 3:35Рм 20 Earley Green June Portia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Olney Montgomery General Hospital Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 20,1923 Wash.,DC If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Months Days 1 □ M 2 🛣 85 Director 578-22-0001 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ire Wedical Evanturer must be notified at 1X Yes 2 □ No Director Washington, DC DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20009 1117 Fairmont Street, N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. Specify: Black ð 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Private Guidance Counselor Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Is marked of Cunningham Leash Albert James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun 20853 4310 Joplin Drive, Rockville, MD Angela E. Brown/Daughter 20b. Place of Disposition (Name of Howard Core Third World File 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/24/09 Washington, DC Medical School 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 20011 3821 14th Street, N.W., Wash., DC -M00996 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line. mediate Cause (Final isease or condition resulting in death) VEARS Physician CARDIOVASUIGE a HTHEROSCLEROTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner and Due to (or as a consequence of): physician a Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform certificate 2 **1** No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Box 68760 P.O. Division of Vital Records, funeral director, After this al or Attending P s after death. To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

cal

29b. Signature and title of certifier

6 Could not be determined

3 Suicide

29a. Certifie

4 Homicide

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRINCE TERRING 18/01 31. Date filed (Month, Day, Year)

JUL 1 0 2009 32. Registrar's Signature

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# Sperf H, G907, 9 / 14 / 2010, W All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 100 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3, 2009 4:45 Ρм Melvin J. Eyler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Baltimore Stella Maris Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 2-21-1929 9. Birthplace (State or Foreign 216¹²22¹¹3756 **Funeral** Months Days Hours Min. Mary Land 80 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Director 1 □ Yes 2 No Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 **USA** 1700 A Bayside Beach Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Specify: white 1 □Yes 2 X No Specify: <u>≽</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) material handler copper refinery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie A. Oetken William H. Eyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 A Bayside Beach Road Pasadena MD 21122 Katherine E. Dungan-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery July 7 2009 Brooklyn Park MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1328 Sulphur Spring Rd, Arbutus MD 21227 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a possequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1∐Yes 2XNo Certification: To 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No after death Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and doess person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

3,2009

32. Registrar's Signature

2300 DULINEY VALLEY RD TIMUNIUM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 100 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day John E. Evans, Sr. 3:10P.M June 30 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death N/A 1400 E. Madison Avenue Apt. 407 Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours Min. 1 □ M 2 □ F 213-30-1193 74 27. 1935 N.Carolina Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits tyE Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1400 E. Madison Avenue Apt. 21205 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 🐉 □ No Specify Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Merchant Seaman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Evans Alice Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 61 0 19a. Informant's Name/Relationship (Type. Print) Jacqueline Paige 2004 Hawkins Street Raleigh, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State aZn9 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Owings Mills, Md 22. Name and Address of Facility 21. Signature of Funeral Service License Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, the as attending nse. for ned by the a signed I has page 2 s certificate or Attending Physician: After this certific funeral director,

Physician

/Medical

Examiner

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ed other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be notified at

of Health and Mental Hygiene.

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Department of F
Important: If Ite
any Injury or ot

Physician /Medical

Examiner

Pages 1

within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical Certification: To Be Completed by

Part II. Other significant conditions (contributing to death but not resulting in the underlying	cause given in Part I.	1 Yes 2 No 3 Probably Unknown					
			24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\superset \text{ves} \) 2 \(\superset \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\superset \text{ves} \) 2 \(\superset \text{No} \)					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ □	OCA Other: 4 Nursing Home	Residence 6 Other (Specify)					
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 Suicide 6 Could not b 4 Homicide determined		ry, office 28f	f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only) Certifying Pl	nysician: To the best of my knowledge, death occurre	d at the time, date and place, an	d due to the cause(s) and manner as stated.					

To the Hospital within 24 hours a

State

Medical

29b. Signature and title of certifier

e of death (Item 23a) (Type, Print

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete

North 31. Date filed (Month, Day, Registrar's Signature

Registrar

ours after death.

neral Director: Al

completely

			State of Mary State of Mary Registrar		rtment of H tificate of L			ene g. No. 2 A A G	22000
	Physicia /Medic		Decedent's Name (First, Middle, Last) Beulah	Ellis			2. Date of Death Month July	Day Year 5 2009	3. Time of Death 9:30 P. M
The same	Examin		4a. Facility Name (If not institution, give street and number) 5634 Matilda Lane 5. Social Security Number 6. Sex 7. Age (Ir	n yrs. last birthday)	Linth If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	4c. County of Death Anne At 9. Birth	place (State or Foreign
	Funeral Director		214 14 1430 1□ M 2 AF 87 Usual Residence of Decedent		Months Days	Hours Min.	(Month, Day, 04/20/	Year) Coul 1922 Mar	yland Od. Inside City Limits
	be filed within 72 hours after death with the Maryland the Hylylene. do ther than "ratural", or items 23a or 28a-f show other than "ratural", or items 23a or 28a-f show event, I've Medical Evaninar rust be notified at	Funeral Director	Maryland Anne Arundel 10e. Street and Number 5634 Matilda Lane 11. Marital Status 1 □ Never Married 2 □ Married 11. Vess 2 ▼ No		10f. Zip Code 2 Was Decedent of H f Yes, specify Cuba	1090 ispanic Origin? (Sp ın, Mexican, Puerto		U.S.A. 14. Race - Ameri Black, White,	can Indian,
<u> </u>	d within 72 hours at giene. r than "natural", or the Wedical Eram	Completed by	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	□Yes 2፟ANo dent's Usual Occup kind of work done of NOT use retired ler	durina most of worki	ing 1	Specify: Wh 6b. Kind of Business/In MD. Natio	
/land	should be filed of the state of Mental Hygie marked other imatic event, It	To Be C	17. Father's Name (First, Middle, Last) Harry S. Lu	ısby		18. Mother's Name	e (First, Middle, M ma M. Tay		
e, Mar)	permit. Pages 1 and 2 should i Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type. Print) Linda Toedt / Daughter	5634	Matilda	Lane I	Linthicum	City or Town, State, Zin, Maryland	21090
aitimore	Pages 1 iment of H iant; If iter		1 M Buriai 2 Li Cremation 3 Li Hemovai from State	20b. Place of Dispos cemetery, crem Cedar Hil	1 Cemete	cy 07/09		Baltimore,	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Part 1, Enter the disease are complications that caused the	hi 4		nie Highwa	ay Balt:	ral Service imore, Mary	e, P.A. land 21225 Approximate
	Physician /Medical Examiner		shock, or heart failur. Only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	eheim		em en	,	4	Interval Between Onset and Death
8/60,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to time data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Sub to (or as a condition of the c	·					
O. Box b	ician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 ☑ No 9 □ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date of deliv	very Day Year
ras, r	quires that in signed build be deta	by	Part II. Other significant conditions contributing to death but n	ot resulting in the ur	/ 5	en in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2₽100 3□ Pro	the cause of death?
Hec	aw as b	Completed	-				24a. Was an autopsy perform	y prior to coned? death?	opsy findings available ompletion of cause of
on or vital	ng Phys fter this ineral di	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Yes) 2 ☐ Accident investigation	2 ER/Outpatier (ear) 28b. Time of Injury	f 28c. Injur Wor	er: 4 □ Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 ☐ Other (Spec	ify)
DIVISION	al or Atter s after dea al Director ed in by the	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of n 2 □ Medical Examiner: On the basis of examiner states	camination and/or in	vestigation, in my	opinion, death occur	rred at the time, da	ate and place, and due	to the cause(s)
	To To Con	Σ	29b. Signature and tipe of certifier Column Carle	nij	29c. Licens	114.59) 29	July 6, 2	009
			30. Name and address of person who completed cause of deat Convince Convince August 131. Date filed (Month, Day, Year) 32. Registrar's	1.D. 4	7w Re	uning	ton A	se Balt	o.Md
	Sta Registr		JUL 1 0 2009 Seren	w B. A	Jacks	/			21260

Registrar